
COLLEGE OF NURSING
INTELLIGE
WAYNE UN
R.N.
FEBRUARY - 1952

Mary Lou was a crackerjack nurse,

But her hands took a turn for the worse!

They were red, rough 'n' raw

'Till she PACQUIN-ed each paw—

Now her patients are penning her verse!

● Pacquins Hand Cream was developed especially for doctors and nurses who give their hands so many scrubbings. Now more women use Pacquins than any other hand cream! Use it for soft, lovely hands. For extra-dry skin, red label Pacquins—contains lanolin.

FOR DREAM HANDS, CREAM YOUR HANDS WITH

Pacquins *HAND CREAM*

On sale at all drug counters in U.S. and Canada

R.N. CONTENTS • February • 1952

Vol. 15
No. 5

COVER CREDITS: Photographer: Walter Herstatt; Cap and pin: Wayne University College of Nursing, Detroit, Michigan

CCA

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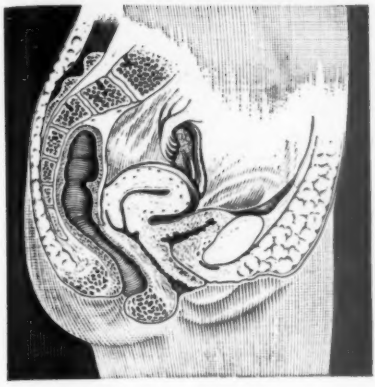
NBP

let's meet R.N. authors

Alfred J. Cronin makes his R.N. debut with his article on income tax returns. It's a bugaboo subject, but he does his best to simplify those intricate tax form instructions. A certified public accountant, he's with the New York accounting firm of Murphy, Lanier & Quinn, but send your fan mail to us, not New York.

Did somebody say private duty nurses aren't active in association affairs? Well, **Florence Thorson** (University of Minnesota School of Nursing) and **Mary Tillman** (Seton School of Nursing, Colorado Springs) are, respectively, president and secretary of the Twin Cities Professional Nurses' Credit Union and officers in state and district private duty associations. Associate editor Frances Lewis met them when she attended Minnesota's convention. After hearing their vivid description of how a credit union works—and what it can do for nurse members—she was convinced we should publish an article on the subject. Result: the happy collaboration on page 48.

Frances Gibson's byline first appeared in our October, 1947 issue. A graduate of The Jewish Hospital School of Nursing, St. Louis, with a University of Oklahoma M.A. she's a native Southerner with a real talent for both poetry and prose. Presently a pediatrics' instructor, she's just completed a novel which a publisher is considering.



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CREAM *with 9-Aminoacridine*

Here are the facts! A.V.C. IMPROVED is specific for the treatment of Trichomonas vaginalis vaginitis. This statement is substantiated by cumulative clinical evidence.

For example... Hensel* reports: "Symptomatic and bacteriologic cures were obtained in all of the 39 patients with Trichomonas vaginalis vaginitis, treated with A. V. C. IMPROVED. It was equally effective in monilial vaginitis and in nonspecific vaginitis."

*Hensel, Hubert A.: Postgraduate Medicine, 4:293-296, October, 1950.

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Please send me a sample of 'Wellcome' ®brand Toilet Lanoline with Solid and Liquid Petrolatum.

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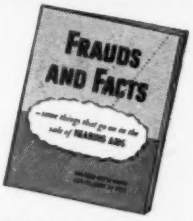
How you may help the Hard-of-Hearing save $100 or more!



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. . . the truth about Hearing Aids

As you know, many hard-of-hearing persons hesitate to acquire a hearing aid because of confusion and suspicion about conflicting claims. Perhaps you are caring for someone in this position, someone who wonders: "What does the Council on Physical Medicine and Rehabilitation of the American Medical Association say about hearing aids?" "How can I know what maker tells the truth about his product?" "How much should a hearing aid cost?"

Now you can help these people! Their questions are answered in a new book—published by Zenith Radio Corporation to give the truth about hearing aid claims—to save the hard-of-hearing disappointment and needless expense. Physicians everywhere have received "Frauds and Facts," and Zenith feels that you, too, should have the opportunity to read it. "Frauds and Facts" was inspired by the Council's article, "Hearing Aids and Advertising," in the June 16, 1951 issue of *The Journal of the AMA*.

You may obtain a free copy of "Frauds and Facts" by sending in the coupon below. Read this revealing book, and pass its information along to persons under your care—you will be doing them an additional service. And do let us hear your own comments.

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checks diaper odor

as well as diaper rash!

in the UNBREAKABLE SQUEEZE BOTTLE...

Mennen Baby Magic is soothing . . . lastingly fragrant! A fast-absorbing, non-greasy liquefied cream.

Tell mothers it saves time . . . safer, too! Sanitary Squeeze Bottle can't break. Comes in dainty pink or blue to match nursery!

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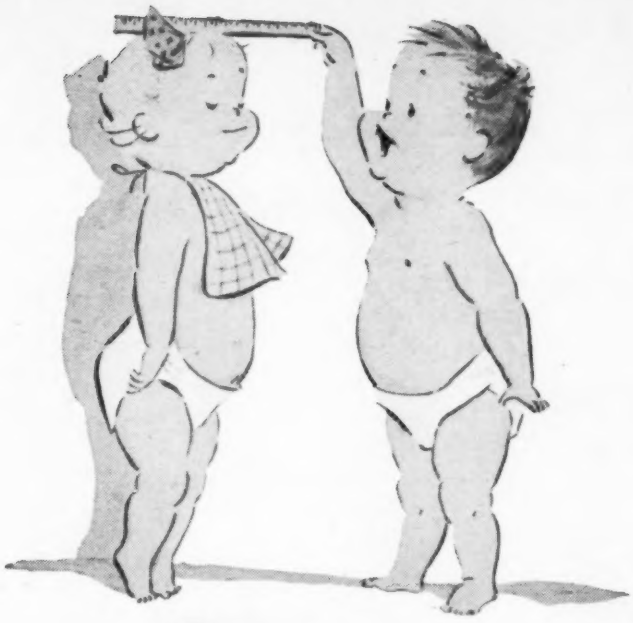
Baby Magic

SKIN CARE

WE'D LOVE TO SEND YOU this full-size, 49c bottle of Baby Magic . . . for only 25c (to defray mailing and handling costs). Once you see how easy it is to use, how much it does for the infant's skin . . . we know you will recommend it to mothers. Send your name, address and 25c to The Mennen Company, Department RN-2, 345 Central Avenue, Newark 4, New Jersey. Offer good only until April 1, 1952.



...and 29 to grow on!

Knowing the importance of variety in pediatric diets, Gerber's offer you the most complete line of strained foods. There's real prescription selectivity when you can make your suggestions from starting cereals through 30 varieties of fruits, soups, vegetables, desserts—even meats.

You can count on baby's acceptance of Gerber's, too . . . an important factor in building future good eating habits. For besides the quality you look for, Gerber's also offer the purée-like texture and bland taste that appeal to little tongues . . . are easy on little stomachs.

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DEBITS & CREDITS

AN APT DEFINITION

Dear Editor:

I read the following definition in an advertisement not so long ago, and it seemed to me worth sharing. "The difference between a profession and an occupation is subtle, but strong. An occupation is a living. A profession is a way of life—richly rewarded by prestige, it is true, but strictly penalized by responsibility. A professional person must have integrity and interest, conscience and character, pride in his profession and a zeal for perfection."

The general trend today seems to be to make nursing an occupation.

May **R.N.** continue to strive for nursing as a profession.

(Mrs.) Ruth M. Franklin, R.N.
CATSKILL, N.Y.

INTANGIBLE WEALTH

Dear Editor:

I find it difficult to explain why I prefer nursing to any other profession or occupation open to women. Certainly, it has more than its share of headaches, backaches, footaches and heartaches—but it also gives an intangible wealth, made up of practical experience, theoretical knowledge and also pure human interest. Not an hour passes in a hospital without some incident engraving itself upon the memory. There is time for laughter and for tears a dozen times a day.

In place of a good "whodunit," I recommend following a difficult diagnostic problem to its eventual solution. It has all the elements of a thriller: mystery, suspense and clues (true and false).

And for variety, consider the hundred new patients who walk through the doors of the Out-Patient Department in a day seeking help and healing. At the admitting desk things happen that tear your heart out, or make you feel like tearing your hair.

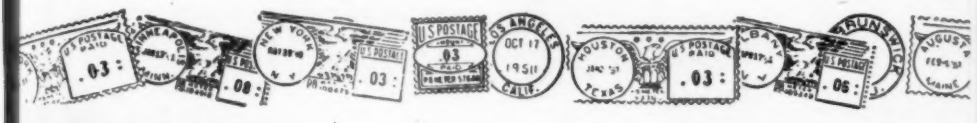
These, and countless other episodes are part of the intangible wealth of nursing. They explain, in part at least, why there is always another side to the picture of nursing —a side of never-failing interest which makes all of us, as we put a white cap on our heads and fasten our hospital pin upon a uniform, proud to be numbered in the ranks of registered professional nurses.

R.N., DEMAREST, N.J.

GROUP NURSING

Dear Editor:

You really made a contribution to the field of private duty nursing with your panel on private duty in the November, 1951 **R.N.** I think it is



the nicest thing that ever happened to us.

The panel really put a finger on the greatest objection to "group nursing" when the point was made that hospitals are not constructed for it. I've done a little group nursing myself, in a hospital where rooms were built with a connecting bath.

If either case is complicated or extremely risky, then group nursing is out in private duty; at least until some really revolutionary architecture is devised. But where it is possible, I rather like it; especially on night duty, when it breaks the monotony of a long night, as well as being slightly more remunerative for the nurse, and slightly less costly for the patient. Most nurses I know would rather be busy on duty than have too much time on their hands. Yet, if the night nurse does her duty well (which is to keep the patient safe and comfortable enough to get a good night's rest), she of necessity has time on her hands—with only one patient.

(MRS.) FLORA MURRAY, R.N.
SAN ANTONIO, TEX.

ON PRIVATE DUTY

Dear Editor:

I think R.N. deserves much credit for publishing the articles on private duty nursing in the November, 1951 issue. Private duty today is the stepchild of professional nursing, and in many ways rightly so. The acceptance of hospitals and registries of nurses who are unqualified or ineligible for

other positions is, in my opinion, greatly to blame for the present lack of prestige. Perhaps a study of private duty, with its important link to psychosomatic medicine, could be included in the curriculum of our nursing schools. This, I believe, would do much to stimulate the interest of the student, and clarify the purpose of this vital nursing service.

Miss Geister covered a great deal of controversial territory in the panel discussion in her statement that, "private duty nursing should be taken out of the hospital's no-man's land and integrated with its operations and policies." I am sure many nurses agree that if nursing educators would include private duty in their planning, it would elevate the standards and recruit nurses who otherwise avoid private duty because of the negative attitude of many hospitals toward the field. The field of private duty has too fine a tradition and includes too many seriously dedicated people to justify its continued classification on the lowest rung of the professional ladder.

(Mrs.) Lisbeth Sutherland, R.N.
PITTSBURGH, PA.

CALL FOR CAUTION

Dear Editor:

As an American I am vitally interested in safeguarding the many freedoms, liberties and rights of all Americans. As far as the nursing profession is concerned, I believe that resorting to federal aid for nursing education will not solve our difficulties by alleviating the shortages and the problems of finance, but rather will have

to be sure... Always

Rx, for yourself, daily, routine use of soothing, deodorant, pleasantly scented **Bo-Car-Al®**, to be sure . . . always . . . of proper feminine hygiene. This widely prescribed vaginal douche possesses mild antiseptic properties in solution, and a pH of 3.0 to 4.0, which helps to preserve a normal vaginal pH with freedom from infection. A daily **Bo-Car-Al** douche is an easy, inexpensive, *sensible* way to be sure . . . always! Write today for a free sample of **Bo-Car-Al** powder.

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Without charge, please send me a trial packet of *Bo-Car-Al* Hygienic Powder.

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a tendency to create a control by snowballing, and result in more headaches and much larger problems than exist now. Federal aid might, it is true, temporarily solve some of our problems, but in the long run I believe it is a socialistic trend, and a severe threat to our nation's welfare. Like so many other persons and organizations in the past fifteen to twenty years, I'm afraid that we as an organization and profession have been influenced into running to the Federal government with our problems instead of seriously attempting to solve them ourselves. Furthermore, I'm fearful that this supposed innocent acceptance of federal funds is a subterfuge for socialized medicine, and might lead to the same type of program that has been tried without success in the socialized countries of Britain, New Zealand and Germany. The fact that we in America maintain higher standards of health than almost any country in the world today should argue against changing to a system not equal to our own. Should we not proceed with caution as a profession lest we regret our actions in years to come by becoming too dependent upon government financial aid and its resultant evils?

(Mrs.) Lena Wendell, R.N.
Omaha, Neb.

DUPED

Dear Editor:

After reading an article on camp nursing in R.N. [April, 1951], I decided last summer to work at a boys' camp. The Director told me before I

5 out of 6 gynecologists approve tampons, like Meds, for normal women

. . . according to a recent national survey made by the Johnson & Johnson Research Foundation of 900 leading gynecologists and obstetricians.

In this same survey 4 out of 5 doctors reported that it is safe to swim during menstruation provided the water is not too cold. Also, when Meds are worn, you can shower, bathe.

Meds Were Perfected by a Gynecologist

. . . and are made of snowy white, highly absorbent, surgical cotton, and each is individually wrapped for additional protection. They are easier, quicker to insert, thanks to the new, improved applicator. Meds, the Modess tampon, are made by one of the most trusted names in the hygiene field.

Meds Provide Comfort

. . . assurance, undreamed-of peace of mind. They come in Junior, Regular and Super sizes. Since they are worn internally, they eliminate pads, pins, belts . . . end chafing and odor.

Single Girls Can Use Meds

. . . thousands and thousands of them do every month since the use of Meds in no way changes the physical structure. Because we are so sure that you too will like Meds once you've tried them, we want you to do so at our expense. In addition, you and your friends may like copies of the educational booklet on menstruation "It's So Much Easier When You Know." For FREE copies and Meds sample just fill out and mail the coupon below.

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Please send me your Meds booklet and sample. (Check size) Junior____, Regular ____, Super____. (One to a family. U.S. only.)

Name_____

Address_____

City_____

State_____

signed an 8-week contract that when the doctor was in camp I would be free to leave, and vice versa. After I started working, I found out that I was only allowed out of camp when I did not have a patient in the infirmary. With over 90 boys someone was always admitted; consequently, I did 24-hour duty, 7 days a week. The doctors were free to come and go at all times. They merely spent 15 minutes after breakfast and then vanished for the day on pleasure trips. I also found out that I held the most responsible position in the camp but received the same amount of pay as two teachers who had one day off weekly and every evening free. Camp nursing is not a vacation by any means. I was busy all day with hot soaks for infections, allergy injections, penicillin injections, removing foreign bodies from eyes, splinters, sprains, fractures of the leg and arm, asthmatic attacks at night plus perpetual cuts, bruises, poison ivy, etc. I was the only nurse and was told that one was all they ever had.

(MRS.) ELEANOR GARNETT, R.N.
PASSAIC, N.J.

[*We hate to think any article in* R.N. *led to this. Our only suggestion, to avoid such a situation, is read your written contract carefully—avoid gimmick phrases such as "the camp must be covered at all times by the doctor or the nurse" and look for definite phraseology on time off for the* nurse *and hours of work. Also, find out how many will be in camp and whether it has more than one nurse if the number is high. We still say that camp nursing should have some fun attached.*—THE EDITORS]

"meat without salt is fit only for dogs"

HEBREW PROVERB

When your cardiac or other patients requiring salt restriction find that the flavor of salt is essential to their enjoyment of food, Neocurtasal—sodium-free salt substitute—will give the desired salty tang to otherwise "flat" foods.

Neocurtasal®

Neocurtasal is completely sodium-free. It contains potassium chloride, ammonium chloride, potassium formate, calcium formate, magnesium citrate and starch. Potassium content 36%; chloride 39.3%; calcium 0.3%; magnesium 0.2%.

Available in convenient 2 oz. shakers and 8 oz. bottles.

Write for pad of diet sheets..... Winthrop-Stearns INC.

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America's Finest Soils Give Heinz Baby Foods Extra Nutritive Value!

Heinz Knows You Want The Babies In Your Care To Enjoy Mineral-Rich, Vitamin-Packed Fruits And Vegetables From The Nation's Most Fertile Farms. That's Why Heinz Kitchens Are Located In America's Richest Growing Regions—So We Can Scientifically Process Baby Foods Of Maximum Nutritive Value, Finer Flavor, Color And Texture!

Here's Why Doctors Everywhere Recommend Heinz Baby Foods:

1. Heinz kitchens are located in the heart of America's most fertile garden spots—so no time is lost between field and kettle.

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3. Heinz quality is laboratory controlled for absolute uniformity.

4. Better-tasting Heinz Baby Foods are backed by the 83-year-old 57 symbol of quality.

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OVER 50 VARIETIES: STRAINED FOODS . . . JUNIOR FOODS . . . PRE-COOKED CEREAL FOODS . . . PRE-COOKED OATMEAL . . . PRE-COOKED BARLEY CEREAL

NOW . . . help for patients with breath problems

In 74% of cases tested

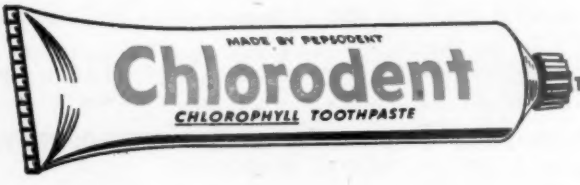
Chlorodent

the chlorophyll toothpaste kept breath fresh four hours or more.

THIS NEW green toothpaste made by Pepsodent was recently tested at a New York laboratory. Results—Chlorodent, containing water-soluble chlorophyllins, kept breath clean for two hours in 98% of cases tested—for four hours in 74% of cases.

What's more, Chlorodent promotes the growth of healthy gingival tissue . . . thoroughly cleans and polishes teeth. For complete mouth care between visits, we suggest you recommend Chlorodent toothpaste to your patients.

Nearly 1000 breath tests made by the osmometer showed Chlorodent's effectiveness in combating mouth odor.



The New Chlorophyll Toothpaste

SCIENCE SHORTS

Banthine, a drug used to reduce the hypermotility and hyperacidity in peptic ulcer, also appears to be of value in the treatment of excessive perspiration and associated skin conditions. In an article appearing in the *Archives of Dermatology and Syphilology,* Drs. Crawford S. Brown of Boston and I. Lewis Sandler of Washington state that out of 27 persons suffering from these disorders who were given oral doses of Banthine, 74 per cent showed marked improvement, and 19 per cent and 7 per cent respectively showed moderate and slight improvement.

*

Operative cholangiography, a diagnostic procedure in which radiopaque Diodrast is injected directly into the common duct, is described in the Annals of Surgery *as a safe, quick and simple x-ray method for diagnosing gall bladder disorders prior to surgery.*

*

The mortality rate of a group of over 50,000 men and women limited to substandard insurance because of obesity was about 50 per cent higher than that of persons accepted for standard insurance, according to Dr. Louis I. Dublin of the Metropolitan Life Insurance Company. The high mortality of the overweight group was accounted for by the high death rates from diseases of the heart and blood vessels, diabetes, cirrhosis of the liver, gall stones and acute appendicitis attacks.

*

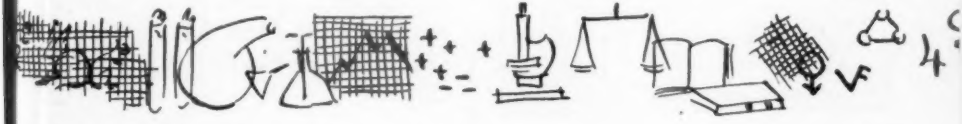
The AMA's Council on Industrial Health states that although women workers have more frequent illnesses and lose more time on the job from sickness than men, the latter are indisposed for longer periods.

*

Sedentary pursuits such as watching television and driving an automobile pose a problem for nutrition experts, according to Dr. Charles G. King, scientific director of the Nutrition Foundation, Inc. Although a large number of people do lighter work than formerly, with an expenditure of fewer calories, they require almost as many vitamins, minerals and proteins as they did when they were working harder. In the opinion of Dr. King, "weight reducing attempts on the part of the modern television addict" and the "fast traveling automobile passenger" may lead to sub-standard nutrition unless the food supply is of higher nutritive value.

*

Members attending a recent meeting of the American Association of Blood Banks were told by Dr. Carl V. Moore of St. Louis that frequent



blood donors should supplement their diet with iron tablets in order to prevent anemia.

*

A preliminary study of the dental caries-preventive potential of a sugar-free chewing gum containing a nitrofuran called Furadroxyl, as reported in the *JADA*, revealed that the after-meal use of this product during peak periods of caries activity, markedly reduced dental decay in 30 caries-susceptible persons.

*

A more durable dye for color markings on clinical thermometers has been developed by researchers at the National Bureau of Standards who have been working on the project for four years.

*

Experimentations on mice cancer with ultrasound—noise vibrating at the rate of 800,000 times a second—have led Mayo Clinic researchers to report that sounding devices may be of therapeutic benefit in the treatment of tumors, especially small subcutaneous ones.

*

It has been estimated that deaths from all forms of tuberculosis in 1949 amounted to 39,000.

*

Four ounces of orange or grapefruit juice taken 30 to 60 minutes before the noon and evening meals have been found to curb the appetites of patients on low-calorie, high protein diets, according to a study by Norman Jolliffe and Elmer Alpert of the Department of Health, New York City.

IN PSORIASIS
despondency and skin patches
both clear up with RIASOL

Despondency, severe neuroses and even suicide may result from the humiliation caused by psoriasis. Hence the best treatment for the mental condition is to clear up the disfiguring skin patches with effective local treatment.

RIASOL does double duty. *Directly*, it clears up or greatly improves the cutaneous lesions of psoriasis in the great majority of cases. *Indirectly*, it removes the psychological cause of the despondency and neurosis.

RIASOL is effective because of its deep action in the layers of the epidermis where the lesions of psoriasis are located.

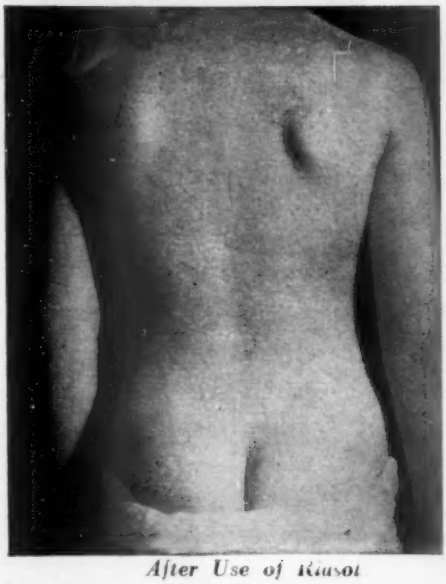
RIASOL usually acts fast, clearing up the skin patches in an average period of less than 8 weeks.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin, invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

Ethically promoted RIASOL is supplied in 4 and 8 fld. oz. bottles, at pharmacies or direct.

Before Use of Riasol



After Use of Riasol

MAIL COUPON TODAY—TEST RIASOL YOURSELF

SHIELD LABORATORIES
12850 Mansfield Ave., Detroit 27, Mich.

Please print name and address plainly. Not sent without Reg. No. R.N.-2-52

Please send me professional literature and generous clinical package of RIASOL.

..... R.N. Reg. No. .....

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City ..... Zone ..... State .....

RIASOL FOR PSORIASIS


HOME
TREATMENT
for the
bedridden
OFFICE
TREATMENT
for the
ambulatory patient

ACTHAR* *Gel* IS LONG-ACTING

ACTHAR *Gel*—the new LONG-ACTING repository preparation—simplifies ACTH therapy comparable to the management of diabetes with long-acting insulin. Home or office treatments become readily applicable with substantial economy to the patient. Greatly prolonged therapeutic action and convenience of administration are distinct advantages of ACTHAR *Gel*.

Recent clinical studies have firmly established the recommended dosage of ACTHAR *Gel*. Established dosage for optimum therapeutic effects is important in the everyday use of ACTH in your practice.

Indications: Rheumatoid arthritis, rheumatic fever, acute lupus erythematosus, drug sensitivities, severe bronchial asthma, contact dermatitis, most acute inflammatory diseases of the eye, acute pemphigus, exfoliative dermatitis, ulcerative colitis, acute gouty arthritis, secondary adrenal cortical hypofunction. **Supplied:** 5 cc. multiple dose vial containing 20 I.U. per cc., and 5 cc. multiple dose vial containing 40 I.U. per cc.

*THE ARMOUR LABORATORIES BRAND OF ADRENOCORTICOTROPIC HORMONE (A.C.T.H.)

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CHICAGO 11, ILLINOIS

world-wide dependability

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

R.N. SPEAKS: And what o

■ ALTHOUGH A NEW organizational structure may provide the framework for closer integration and efficiency, it does not automatically herald a golden era of unity and augmented membership. From where we sit, it appears that while the profession has been going full speed ahead with elaborate plans to increase organizational efficiency and eliminate unnecessary duplications in services, a vital drawback to organizational growth has been given little recognition.

How to attract and keep members in our professional association is and has been the bane of the profession's existence. Even in face of the accelerated ANA program, why have so few, comparatively speaking, sought membership in the parent organization? Why have so many, who have held membership at one time or another, withdrawn from the ANA?

"We can't afford it . . . Too much to pay out in a lump sum . . . Payment of dues always falls between Christmas and March 15 . . . I never have the ready money." Is it not a real stumbling block to membership when nurses can't *afford* to belong to their professional association? And what is being done to bring membership dues within the financial range that nurses can afford? . . . Nothing!

At present, ANA dues are $3 a year. After the Biennial in June, if the ANA House of Delegates so wills, national dues will be $5 a year. Prevailing state dues range from the unusual low of $3.50 to the more prevalent $20 annually. Dues in district associations can be safely estimated as an average of about $2 annually. Almost without exception it will be found that districts engage in raffles and various types of shows and sales to produce sufficient funds to carry out the minimum services to their members. It costs districts considerable money, time and effort to collect dues, give receipts, campaign for new members, bank the dues, type up duplicate lists of membership, and keep current changes of address—all this for both the state and national bodies without remuneration. And how many district budgets can afford a paid executive secretary or clerical assistance with the pittance they must operate on?

"Our district associations are poverty stricken . . . Districts are hav-

our understructure?

ing a terrific time trying to keep afloat these days with the small allocation of dues and increased services and higher costs . . . We give so much service to the state and national . . . Besides paying the national for every member and so much to the state, we in the district who give the most direct service get the least."

We hear from the state level: "Too much leaves the state for the national . . . The ANA is richer proportionately than the states . . . The national can buy favors through paying traveling expenses to institutes and workshops." Here are no idle complaints. These voices reflect the many who have been trying to make their weak cries for financial help heard above the din of national reorganization.

As interested as we are in national planning, we are also well aware that an organization topheavy in superstructure can be as unsound as a building of the same architectural disproportion. We strongly oppose any plan that builds up its strength at the expense of the solvency of the state and district.

It should be apparent that it is high time provision be made for more equitable division of nurses' dues among the district, state and national associations. When a professional organization which has become big business—worth over a half a million dollars in national dues—makes it necessary for nurse volunteers in the districts to devise ways of raising money outside of dues in order to survive, its financial structure certainly needs questioning.

It has been suggested, and we recommend, that the following proposal be given consideration: national and state associations should pay districts so much per member for service charges for collection and handling of dues. A service charge as small as 10 cents per member would not defray the cost of a district sending $60,000 a year to state and national, but it would certainly help meet part of the costs of the transactions.

With more equitable distribution of dues, part of the membership problem would be alleviated. But still remains the hard fact that many nurses cannot *afford* to be members. Other [*Continued on page* 61]

Talking of Taxes

THE R.N.'s 1951 INCOME TAX RETURN

by Alfred J. Cronin

■ LIKE IT OR NOT you have a business partner—the income tax collector. Of late his "bite" into your annual income has been increasing at an alarming rate. For example, consider Miss R.N., single with no dependents, who worked at her local hospital for a salary of $3,000 in 1950 and 1951, and expects to earn the same in 1952. Look at the dizzy spiral of her income tax bill: 1950—$373; 1951—$435; 1952—$474.

With such high tax rates, you just cannot afford to take a casual approach to this business of making out your annual income tax return.

How Do I Pay My Tax?

Before dissecting the tax form, let's take a quick look at the way you now pay your tax. You are on a pay-as-you-go system, that is, you pay taxes currently as you earn income during the year. If you work for a salary, your employer withholds tax from each pay check; he sends the tax to the Collector. At the end of the year, or sooner if you change jobs, the employer gives you a statement (Form W-2) showing earnings and the tax withheld.

On the other hand, if you are self-employed collecting fees direct from patients, you must estimate your tax based upon anticipated earnings. A formal estimate of tax must be filed with the Collector and you pay the estimated tax approximately each quarter; penalties are provided in the law for substantial under-estimates of tax.

On or before the March 15th deadline you make out your tax return for the previous year and generally compute your total tax on the form. Next you deduct from the total the tax you already paid by way of withholding from salary or quarterly on your own estimate. Any balance due the government must be paid with the return; any balance due you will, at your own wishes, be refunded or be applied against your next year's estimated tax.

The Tax Form Outlined

Fortunately, the government has produced an amazingly good job of reducing the legalistic, ever-changing hodge-podge of the tax law to readily understandable language both on the income tax form and in the instruction booklet which accompanies the form.

You will not find this same step-by-step arrangement on your tax form, but here's the way your tax is usually computed. First, determine your "adjusted gross income;" then reduce it by your "deductions" to arrive at net income. From net income you take off your "exemptions." What's left is the balance of income subject to tax; merely apply the tax rates and presto

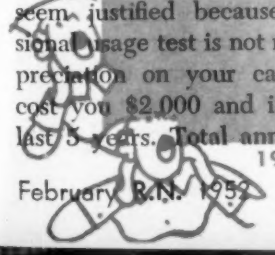
–there's your total tax. If you file a joint return with your husband the final step is changed slightly but we'll discuss that later.

What Is "Adjusted Gross Income"?

Though somewhat scary a title, it's merely the sum of salary, dividends, interest, rents, professional (private duty) fees less professional expenses incurred in earning such fees, and other miscellaneous income. For tax purposes, the private duty nurse has her own business; the salaried nurse is an employe. Being in business, the private duty R.N. makes out a separate schedule (Schedule C) as part of her tax return on which she shows fees received and expenses incurred in earning those fees. Expenses include the cost of uniforms and their laundering, drugs and medical supplies, agency fees, subscriptions to professional periodicals, convention expenses, travel, stationery and postage, telephone and rent of space used for professional purposes. Likewise, automobile expenses, including annual depreciation, to the extent the car is used professionally, should be shown here. When claiming such items as telephone, rent, and car expense, your deduction should be limited to that part of the total of each expense as represents actual professional usage. For example, if all your work is done in patients' homes or in hospitals, a deduction for part of the rent of your own apartment does not seem justified because the professional usage test is not met. As to depreciation on your car, suppose it cost you $2,000 and is expected to last 5 years. Total annual depreciation therefore is $400. If you use the car 50 per cent for professional use in making home calls, etc. a deduction of $200 seems to be in order. The government will not permit you to claim as an expense the cost of taking post-graduate or refresher courses.

The salaried R.N. is treated just like any other employe for tax purposes. In determining her adjusted gross income, if she incurs travel expenses for overnight trips away from home on her employer's business, she should deduct these expenses from her salary, and show the net figure on page 1, Item 2 of tax blank (Form 1040). As for the expenses of uniforms, periodicals, etc., the government unfortunately will not permit an "employe" to take these items into account in computing "adjusted gross income." The salaried nurse can only claim these items, to the extent that she is not reimbursed, as deductions on page 3 of her return.

Remember that tax-exempt income is to be excluded from your tax form. For example, nurses commissioned in the armed forces, serving in the Korean combat zone, or hospitalized as a result of such service should exclude from taxable income the first $200 of each month's salary. The government says that the income report it gives any such nurse will exclude this $200 but it's a point worth checking. Likewise, R.N.'s receiving disability (not retirement) pensions for prior service in the armed forces should exclude such pensions from taxable income. Allowances to nurses in the armed forces for uniforms,



quarters, and subsistence are also tax-free. Meals and lodging furnished nurses for the convenience of their employers are likewise non-taxable.

The Question of Deductions

In common with other taxpayers, the R.N. is permitted to reduce her taxable income for certain kinds of personal expenditures, and page 3 of your tax blank (Form 1040) is where you list these items.

These items include: contributions in money or property (not services) to recognized non-profit religious, educational, and charitable groups (contributions to individuals, political parties, etc. don't count); also interest paid on loans, notes, mortgages; likewise real estate and personal property taxes, state income and local sales taxes, auto license fees and very often state gasoline taxes; and losses from storm damage, fire, theft and other casualties. Medical and dental expenses subject to limitations are also deductible. And finally, other miscellaneous items such as fees for preparing your tax return.

The "Miscellaneous" group is of particular interest to the R.N. working for a salary, for it is at this point that she is permitted to deduct her professional expenses such as uniform cost and upkeep, nursing magazines and periodicals, convention expenses and certain other professional expenses for which she has not been reimbursed by her employer. Note that commutation expenses to and from your regular place of employment are not deductible. Nurses commissioned in the armed forces should deduct here the cost of service insignia and devices, but the cost of service uniforms which replace civilian clothing is not deductible.

Some of these deductions are subject to limitations in the law. For example, regardless of how large your actual contributions were, you cannot deduct an amount in excess of 15 per cent of your "adjusted gross income." In the case of medical expenses you can only deduct that part of your unreimbursed expenses that exceeds 5 per cent of your "adjusted gross income" with a maximum deduction of $1,250 if you are the only "exemption" claimed on your return. To illustrate, if your actual 1951 medical expenses total $600 and your adjusted gross income was $3,000 your medical deduction is $450 ($600 less 5 per cent of $3,000). A new provision in the 1951 law eliminates the 5 per cent limitation if you or your husband reached a 65th birthday by December 31, 1951. Thus, if you or your husband reached age 65 by that date your deduction in the above illustration would have been $600 rather than $450.

The "Alternative Standard Deduction"

To eliminate much bickering and time loss on the part of taxpayers and tax examiners, there were written into the tax law several years back certain provisions permitting each taxpayer to claim, without proof, an automatic deduction of about 10 per cent of his "adjusted gross income" as a so-called standard deduction. Unless you elect to itemize your actual deductions on page 3 of Form

1040 you will compute your tax based on a "standard deduction," regardless of what form of tax return you use. By way of illustration, if your only 1951 income was $3,000 salary and $10 bank interest your "adjusted gross income" totalled $3,010 and your standard deduction is $301 (10 per cent of $3,010).

Thinking of the standard deduction on page 3 of Form 1040, there are two limitations to be kept in mind: (1) On a single person's return or on the joint return of a married couple $1,000 is the top allowable deduction even if adjusted gross income exceeds $10,000. (2) If husband and wife file separate returns (which generally costs more in total tax), neither one can claim more than $500 of standard deduction on their own return. Also remember that on separate returns husband and wife must both use the standard deduction or both must itemize their actual deductions.

What are "Exemptions"?

Under the law you can reduce your net income (adjusted gross income less deductions) by $600 for each exemption. You don't prorate exemptions for part of a year; either you are entitled to a full $600 or to nothing. Exemptions include yourself, your husband (if he's not filing his own return, or someone else is not claiming him as an exemption); members of your family and close relatives each of whom had less than $600 of taxable gross income in 1951, and each of whom received more than one-half of his support from you

Probie

"This is no time to worry about germs."

(or from you and your husband) during the calendar year 1951.

If you reached your 65th birthday in 1951 or prior, that's another $600 exemption. If you were blind in 1951 add another $600. The same is true for your husband. For example, if husband and wife file a joint return, both were 65 or more on December 31, 1951 and both were blind at that date, then their exemptions total 6 or $3,600.

Here's a possible tax-saving idea. Suppose you personally furnished more than half the support for a niece of your husband in 1951 and the niece had no income of her own. You and your husband should file a joint return to pick up another $600 exemption. If you filed separate returns, you could not claim an exemption for the niece on your return because she is not closely related to you; although the niece is closely related to your husband, he likewise could not claim her as an exemption because he personally did not furnish more than half of the funds required for his niece's support.

Watch out for cases where two grown children each contribute exactly half the support for a dependent parent. Under the law neither child can claim the parent as an exemption because the test is "more than half the support." It would be advisable for the children to vary the support so that at least one of them could legally claim the exemption each year. This point is brought out because a study of the 1951 tax form indicates that the government intends to scrutinize claimed exemptions much more closely than it has in the past.

Social Security Tax on Self-Employed R.N.'s

Starting in 1951, self-employed R.N.'s became liable for a 2¼ per cent tax on their "self-employment income." The purpose of the law is to bring many self-employed people under social security coverage so that on reaching 65 years of age they will have a form of government pension.

The tax is mandatory so that self-employed R.N.'s should secure social security cards from the nearest government regional office, if they do not already have a card.

The tax computation and provision for its payment have been incorporated into your 1951 tax return; the tax due is to be combined with your 1951 income tax liability, and any balance due should be paid when you file your tax return.

Here's how it works. On Schedule C of Form 1040, the self-employed R.N. shows professional fees less professional expenses to arrive at net professional or "self-employment" income. If this figure is less than $400 you have no tax; if it exceeds $400 then you pay 2¼ per cent of the *total* amount, up to a maximum of $3,600, which means you can pay a maximum tax of $81. If a joint tax return is filed by husband and wife and each has self-employment income then each must submit his own Schedule C with the joint tax return.

If a nurse received in 1951 both self-employment income and a salary from which her employer withheld social secur- [*Continued on page* 57]

CAN DID COMMENTS—

How many to make a bargain?

■ RECENTLY, some nurses petitioned a Western hospital administrator to limit the jobs of the employed, untrained non-professional personnel to the nursing services that cannot endanger patients. No reply came from the administrator, but 10 days later a notice appeared on the bulletin board signed by the *medical staff* listing in detail the nursing jobs that came within the non-professional's scope.

"The list included practically everything we do except giving intravenouses," said one of the petitioners. "We wondered why these were omitted when the doctors showed so little regard for patient safety in everything else. We weren't consulted, and we won't be until they run into trouble. Then they'll blame us, as usual. And as usual, we'll wade in and help out. We can't refuse to work in the hospital for there are only two in the town. We've got homes there and we have to work."

This situation puts the questions up to every nurse. How far is this type of encroachment on patient safety and professional ethics to go in the name of "nurse shortages"? Isn't it time for organized nursing, medicine and hospital administration to speak out vigorously against such practices? Shouldn't approval of any hospital be withheld when such practices occur? There's a wide world of difference between using all possible hands in planned cooperation, and using the nursing shortage as an excuse to get away with things that are not right. What excuse could there be for the doctors and administrator who took this arbitrary action? I do not know who owns their hospital but the patients under its roof are a public trust whose needs and rights take precedence over blind arrogance. Everything we know today points to the fact that unless, or until, there is joint planning, we cannot bring our full nurse power to the job of nursing care. Nor can we use the wisdom of experienced nurses for the best protection of patients. Some decisions regarding nursing education and practice must be made jointly; others must remain inviolably in nursing hands. Who but nurses know the line that divides the critical and safe zones in nursing care? In that realm *we* are the ones to diagnose.

These facts are being recognized much more generally than before in medical, hospital and nursing circles; the trend is distinctly in the direction of planned, team nursing with nurses in on the decisions. But the movement is slow, and the field large, and

by Janet M. Geister, R.N.

we still have people with ideas that need modernizing. The severe nursing shortage has brought forth a variety of "experts"—the greater the distance the experts are from the scene of battle, the surer are they of their answers. As a case in point, the report* of a recent meeting of the Illinois Hospital Association includes this gem: "A statement was made that practical nurses should be able to compute dosages and give *any kind of medication*. This assertion did not bring out the expected argument but *was approved by nurses and administrators* alike." (Italics mine)

Now, did the professional nurses present really approve, or were they too startled by the audacity of the statement to speak their minds? How many administrators actually voiced their approval? What do nurse instructors who put countless hours into drilling students in mathematics, maximum dosages and toxicities think about this? And what are the thoughts of the seasoned nurses who so carefully work out the dosages ordered by doctors? I wonder how the patients and their families would react to this idea? The present passion for short cuts, and the dangerous notion in some minds that anyone with good feet and a willing heart can nurse others safely, certainly presents some nineteenth century perils to twentieth century people.

Some believe that nurses resist giving responsibilities to non-professionals because they fear competition. That is a fairly common human trait, certainly not unique to nursing. But the most fervent and most frequent objections we hear from nurses everywhere deal wholly with their fears for patients. "I went across the hall twice a day to irrigate the patient's bladder," relates one private duty nurse. "Her special was a six-week-trained-nurses' aide. She bungled things so, the patient was scared silly." It's not an unusual story. Even if trained practical nurses were willing and able to "give any kind of medication," what's to keep the hordes of untrained people from following suit, once the bars are down?

Professional nurses have generally accepted the definition of a practical nurse developed by representatives of both professional and practical nurse groups. In part it is: "The practical nurse is a person trained to care for selected convalescent subacute and chronically ill patients, and to assist the professional nurse in a team relationship, especially in the care of those more acutely ill." The definition specifies *assist* the professional, not supplant her. It calls for *trained* practical nurses, not just anyone who wants to get on the payroll.

The job of working out the border lines between professional and subsidiary nursing and still protecting patients and keeping faith with graduates is one of the toughest ever given a profession. That there are at present gross inequities no one can deny. A good many of them are not of the professional's making but of allies who should be working *with* us. These inequities have created much resentment [*Continued on page* 72]

*Modern Hospital, Dec., 1951, p. 164.

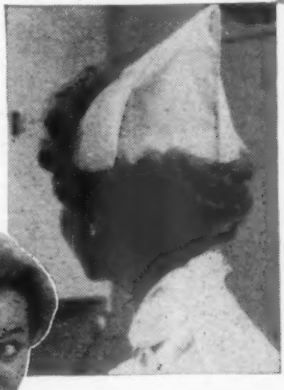
Fashion Notes for nurses by Francia Hughes

3 Hair Stylists create 3 Poodle Hairdos especially for nurses

Though dear to nurses, few claim their caps enhance beauty or relate to current hair-dos. So **R.N.** challenged 3 hair stylists with 3 caps. Amazingly, each evolved a "poodle."

● For the rather severe, squarish cap of the Leonard Morse Hospital in Natick, Mass., RICHARD HUDNUT did a soft poodle with a side-part. Generally becoming, this hair-do is easy to manage, clears the collar.

● VICTOR VITO, headline maker, saw Brooklyn Hospital's cap, came up with a curly "Topsy" convertible to bangs; says use a curling iron and you needn't have natural curls nor a permanent, can give up nighttime pin curls too.



● ENRICO CARUSO did a poodle as pert as the little peaked cap of N.Y.'s St. Vincent's Hospital. The front of this curly-top converts from baby pompadour to bangs; the back gives beautiful balance to the cap.

See page 96 for salon addresses and other fashion sources.

There's Fashion News in Nurses' Uniforms . . .

● 1952 will rate as the year when nurses stopped looking like robots and uniform makers proved that—without sacrificing tradition or efficiency—uniforms could be feminine and flattering. Borrowing a neckline here, a new sleeve there, stereotypes grew into chic, functional costumes, uplifting to nurses' morale.

West Pointers beware! GUILD's No. 2053 outsmarts your braid and buttons; has big pockets; swing-skirt. Poplin, $6.95; Nylon, $14.95.

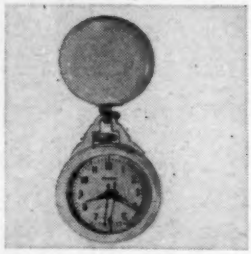
▲ PREEN's No. 238 combines the crisp look of a man's dress-shirt with a full feminine skirt, pleat pockets. Poplin, $6.98.

New! RIPPLETTE, a Sanforized fabric, in BOB EVANS' No. 978. Also new: push-up sleeves, 10-gore skirt, tucked bib. Around $8. ▼

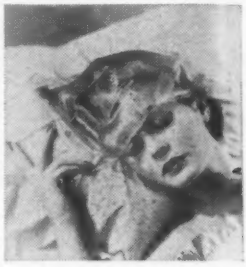
▲ Answer to a nurse's prayer: DOLMAN sleeves—smart, comfortable. DIX-MAKE's No. 400 in Burton's Sanforized poplin, $10.

Demure is the word for BRUCK's No. 5040. Virtues: clerical collar, surgical sleeves, pen-pencil-shears pocket. Poplin, $9.95. ▼

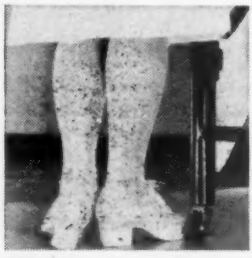
Shop Talk



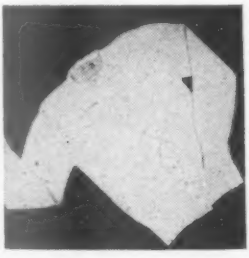
Time on your lapel! Lots of nurses like it there, for lapel-watches seldom get soaked or splashed. Shockproof, this little pendant TIMEX, a sturdy Ingersoll, comes in white enamel with red sweep-second hand; has long, automatic reel-chain. $8.95.



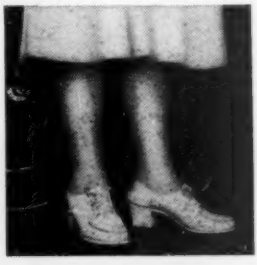
Some like it hot; some like it cold. The DUO-PAC can be both—a durable, Vinylite plastic pack with a chemical solution inside. All "Specials" should carry one. Plunged into hot water for 5 minutes, it stays hot for 30; chilled in the refrigerator, it becomes a wrap-around ice-bag. Cost: around $2.



White nylon stockings, "comfortized," especially for nurses by the NURSE WHITE HOSIERY COMPANY, concern themselves with resisting snags and runs; absorbing perspiration; jiffy washing and drying—typical problems of women who work for hours on their feet. Sheer and service weights, from $1.19 up.



A white nylon cardigan makes the cosy unobtrusive wrap a "Special" needs for those cool nights when her patient's room is ventilated for sleeping. This one, GLAMOUR-KNIT's 100% Nylon classic, has a rib-knit hem, neckband and cuffs; washes and dries, like Nylon stockings, in a twink; costs only $5.95.



Think of a shoe without a single nail in it . . . of soles without ridges . . . of moccasin-vamps without the stiff boxing that cramps most toes . . . and what have you got? A handcrafted "HAY-MAKER," perfect, for nurses, in white leather. The oxford, $14.95.

Neat white pens, pencils, Esterbrook-guaranteed. Fine points for chartwork; automatic pencils. $2 ea. at Bruck's.

NURSING in OHIO

■ NURSING IN OHIO is the proper theme of this first published account of a state's nursing history. But viewed in a wider sense, this might well be the story of nursing in the U.S., so clearly does it reflect the strivings, interprofessional disputes, and achievements of nurses and nursing organizations in the whole of our 48 states. Here, portrayed against a Midwestern backdrop, are the familiar nursing landmarks: the influence of the religious nursing orders; the legislative struggle for nurse licensure; the bleak days of the depression, when Ohio nurses "gave more than $300,000 worth of free nursing service" for the privilege of living and working; and the slow but steady march toward higher educational standards.

Nursing in Ohio was written at the request of the Ohio State Nurses Association which had created a special fund "for a lengthy research and writing program by trained, unbiased historians." In view of this worthy objective, James H. and Mary Jane Rodabaugh, the authors selected for the assignment, were guaranteed complete freedom and independence in their research and preparation.

Yet, despite its broad historical implications, *Nursing in Ohio* is more than a mere reflection of the national nursing scene; it is primarily the story of a strong and progressive state, unique in its ability to produce and attract outstanding nurse leaders. High on Ohio's roster of famous nurses are those who participated in the long battle for nurse registration. Mary Hamer Greenwood, the first president of the Ohio State Nurses Association, Mary E. Gladwin and her sister Anna, Claribel A. Wheeler, Mary M. Roberts, now editor emeritus of the *American Journal of Nursing*, and Ella Phillips Crandall are but a few of the many who helped to mold nursing in Ohio.

No two states approach or solve their nursing problems in exactly the same manner, and apparently Ohio is no exception to the rule. When the Ohio State Nurses Association was organized in 1904 for the purpose of supporting legislation for nurse registration, its officers and members were at once confronted by numerous obstacles, not the least of which was discrimination against the female sex. Because the constitution of Ohio allowed only male electors to hold state office, women were not permitted to serve as members of a board of nurse examiners. As a result, early nursing efforts were directed to amend the state constitution to enable nurses to control their own profession.

Even after the passage of a registration bill in 1915, OSNA support of the suffragist movement was not withdrawn, for women were still being discriminated against. In fact, the 1915 bill almost failed of enactment because of dissension within the nursing ranks, one group strongly contending [*Continued on page* 66]

The Tale of the Tub

by Frances Gibson, R.N.

Designed for lazy people, this eighteenth century "Rube Goldberg" rubber nightgown provided speedy bed baths.

NURSES BATHE countless patients during nursing school days for a bath is considered to be a vital part of total patient care. The student learns the special techniques for giving a bed bath, a tub bath, an infant bath, a sitz bath, a tepid sponge bath, and others, and as a graduate nurse she becomes more bath conscious than ever. The ward assignment in any hospital is usually worked out in terms of how many baths each nurse will give. Nurses and baths sort of go together like salt and pepper and cheese and crackers.* But do we know much about this popular custom that is so much a part of our daily job? How did it get started? Have people always bathed?

I do not know who took the first bath, but I have no doubt that it was originally an accident. I can imagine some prehistoric woman slipping on a muddy shore and toppling into some prehistoric lake, or some little stone age boy dabbling in a cool stream. I do know though that in the dawn of history baths were considered sacred by the ancients. Warm springs were used for baths, and priestesses often lived beside them to honor the gods who lived in them.

*This close relationship elicited a strong protest from the peppery George Bernard Shaw. In 1948, when he was asked to send a message marking the opening of a nurses' training school in London, G.B.S. commented acidly that nurses are "trained to kill" patients with "untimely washings and unwholesome diets." An equally peppery reply was dispatched to the "master" in a cable from ANA executive secretary Ella Best, reminding Shaw that "cleanliness is next to Godliness, even when it happens to be untimely."

Rivers were used for baths, too, as you will recall from the Bible story of Pharoah's daughter bathing in the Nile.

By the time the highly civilized Greeks came along, baths were an accepted part of everyday life. Public baths were always crowded, and it was usual for everyone to be parboiled in hot water every day. The Romans also had beautiful bath houses—so large they often had libraries and shops and theaters. Since they were the center of the social life of the time, everyone went to the bath houses to hear the latest gossip, if for no other reason. A Roman had the choice of a hot bath, a hot air bath, a vapor bath, or a cold bath to be followed by a dip in the swimming pool. The bath started with an oil rub, a vapor bath, then the body was thoroughly scraped with an instrument that looked like a little rake and probably felt like one. The Romans also used soap, a commodity which the Germans had placed on the market.

Bathing, however, was unpopular with the early Christians, chiefly because it was a custom of the heathens and pagans. It was not until the age of the Crusaders that the bath became fashionable once more, and public bath houses flourished. During this period of cleanliness, knights often received callers while lounging in their large barrel bath tubs.

The attitudes of royalty toward baths differed widely. Queen Isabella of Spain was very proud of the fact that she had bathed in water only twice in her life; she preferred perfume. But Louis XIV thoroughly enjoyed his sofa baths and armchair baths, and when Napoleon entered the scene his bathroom was so elaborate that it was the talk of France for years.

In spite of all this, baths were still held largely in disrepute. In 1782, a learned medical treatise stated that washing with water was injurious to the skin, that water made the skin more susceptible to sunburn in summer and to frostbite in winter! In America many of our ancestors considered bathing not quite respectable; some even considered it sinful. It is significant that Benjamin Franklin, who was considered an eccentric, was the first American to own a bathtub—a slipper tub brought from France. As its name implies the tub was shaped like a shoe and had a little door in the heel where one might put in hot coals to keep the water warm. Dolly Madison had a tub put in the White House, but when Andrew Jackson moved in he had it taken out. He was afraid his voters might not approve of such an aristocratic gadget! Philadelphia tried to pass a law forbidding baths in 1843 and, believe it or not, Boston actually did ban bathing from 1845 to 1862.

Fortunately for us, however, modern plumbing eventually triumphed, and the twentieth century in America will probably be long remembered for its accent on cleanliness. Bath tubs have become very much a part of our daily life, and, for the sick, the bath has become an important part of their medical treatment.

DIABETES

by Frances Lewis, R.N.

■ BEFORE THE ADVENT of insulin in 1922, the diabetic patient was generally a marked man—doomed to a short and hazardous life. Even a bonus of a few extra years was not exactly pleasant, for many times this was believed to depend upon his adhering to a tasteless and debilitating diet of sugarless and high fat foods. In the younger age bracket, diabetic children could be expected to survive only a few weeks or months, rarely a year or two, after the onset of the disease. With the discovery of insulin, however, the diabetic picture changed dramatically.

The progress that has been made since the pre-insulin period in treating diabetes mellitus can be read in statistical reports or seen for oneself in the observation of diabetic patients. In a recent study of 760 diabetic individuals who had been afflicted with the disease for 25 years or more, diabetic specialist Dr. Elliott P. Joslin found approximately 80 per cent active, and a few in perfect health. Almost without an exception, the patients who enjoyed the best health had had their diabetes treated early and carefully controlled through the years.

But unfortunately, diabetes today cannot be viewed with complete optimism. Frequently attended by serious complications, it still ranks as one of the major causes of death and there is no evidence that its incidence is decreasing. Some estimates place the number of diabetics in the U.S. at two million; one million of whom have not yet been diagnosed. Several authorities say that the number of potential diabetics is even greater and will increase faster than the rate of increase for the total population. And researchers soberly agree that before diabetes vanishes as a serious health problem much more will have to be known about the etiology, treatment and complications of this metabolic disturbance.

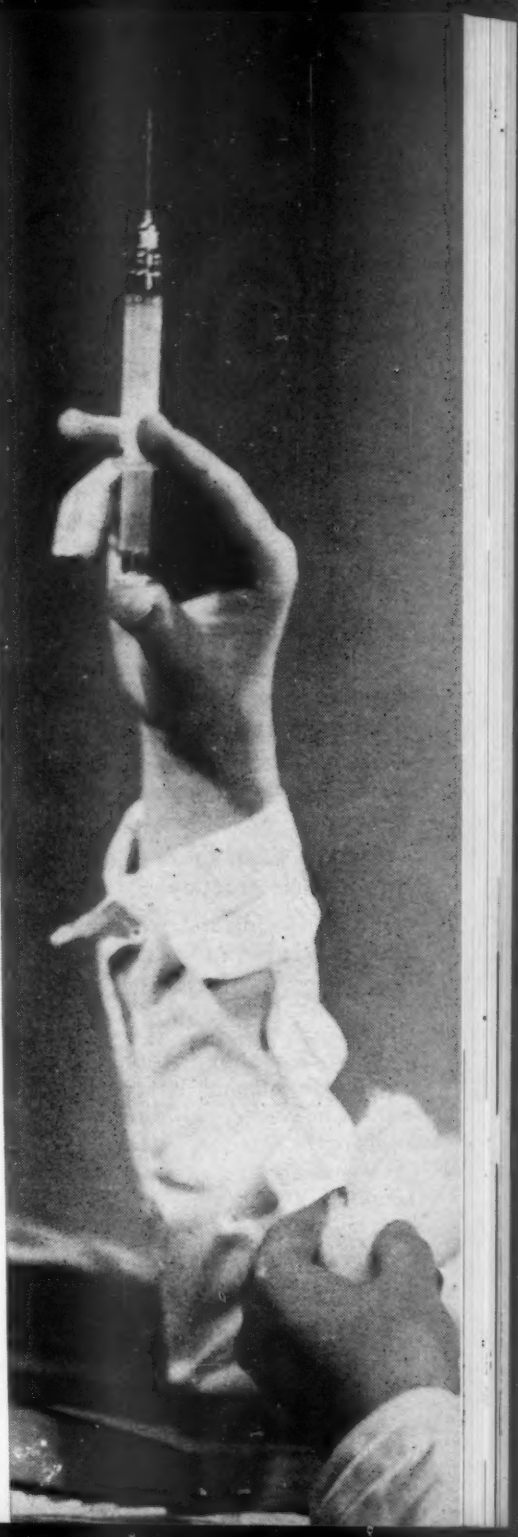
One of the most obvious barriers to the removal of diabetes as a health threat is the relative scarcity of etiological facts. At present diabetes can be more or less satisfactorily controlled, for it is known that commercially prepared insulin can compensate for the lack of the natural insulin normally secreted by the islets of Langerhans in the pancreas. Without insulin, the tissue cells are unable to utilize carbohydrates. As a result, glucose, the principle product of carbohydrate digestion, accumulates in the blood stream and spills over into the urine when it rises above its normal threshold. But despite the very real value of insulin therapy, there is still no sure-fire way of preventing or curing the disease. We do not yet know what are the factors—endocrine or otherwise—which set off the diabetic

sequence of events. When the evidence is sifted, all that can be concluded is the fact that heredity and obesity appear to play significant roles. It is well established that diabetes can be inherited—if not in one generation, in the next—and that it occurs much more frequently in obese persons, particularly the women in that group who are underexercised and overfed.

Because there are no available medical methods for preventing diabetes, other than advising against overweight and marriage of diabetic partners, the skilled doctor of today usually has to confine his efforts to early diagnosis and optimum control of the disease. Prompt detection and immediate and prolonged treatment, most authorities believe, are essential factors in warding off the dreaded complications of acidosis, coma, severe infections and the degenerative diseases.

In his search for diabetic clues, the physician is aided by the laboratory and the patient's symptoms. As a rule, the onset of diabetes in children is acute, and the symptoms of weight loss, fatigue and polyuria lead him directly to the diagnosis. In adults, however, the onset may be so insidious that routine urine examinations frequently reveal the disease before the characteristic symptoms of weight loss, fatigue, increased appetite, thirst, polyuria, pruritus vulvae and visual disturbances appear.

Glycosuria or sugar in the urine can be detected by means of the Benedict test, the Clinitest or the Galatest—all methods which the aver-



POINTERS FOR DIABETIC PATIENTS

- ▶ Follow the prescribed schedule of diet, exercise and administration of insulin.
- ▶ Contact doctor at first sign of injury or infection.
- ▶ Do not squeeze blackheads or boils.
- ▶ Avoid foot complications by wearing correct sizes of shoes and stockings; keep feet clean, use lanolin to prevent corns and calluses.
- ▶ Steer clear of colds and other contagious diseases, particularly TB.
- ▶ Dress warmly in cold weather.
- ▶ Do not use hot water bottles or heating pads.
- ▶ To dilute urine and allay hunger, drink low-caloric liquids such as water, tea with lemon, black coffee or broth.
- ▶ Carry sugar lumps to use in case of an insulin reaction.
- ▶ Change injection sites frequently to prevent irritation and infection.
- ▶ Always use sterile needles and syringe.
- ▶ When syringe is kept in alcohol, evaporate alcohol before injection by repeatedly withdrawing and pressing in plunger. (Alcohol is painful when injected and can inactivate insulin.)
- ▶ After injection, do not rub; press cotton gently over injection site for a few seconds.
- ▶ Keep insulin refrigerated; do not use after expiration date.
- ▶ Keep an extra supply of needles, syringes and insulin on hand.

age person can employ himself as a preliminary to further medical examination. Diabetes is usually suspected by the physician when there is any trace of sugar in the patient's urine, but on no account should this be taken as definite diagnostic proof until further blood studies are done. If the fasting blood sugar levels are high, a diagnosis of diabetes may generally be established. But if they are borderline, or if the patient has a complicating illness or infection, repeated blood tests after meals or glucose tolerance tests after the illness has subsided should be made. It has been stated that specimens of urine and blood are of the greatest diagnostic value when they are obtained after eating, since the blood sugar in a diabetic reaches higher levels and stays elevated for a longer period after eating than does the blood sugar of a normal person.

After the suspect has been definitely labeled as a diabetic, treatment is begun on a purely individual basis. Insulin is prescribed immediately for patients with acidosis or disabling diabetic symptoms, or for those who require immediate control of glycosuria. In the case of other patients, the *Diabetes Guidebook* of the American Diabetes Association[1] states that dietary management without insulin may be tried.

In contrast to the unappetizing diets preceding insulin therapy, the diabetic diets of today resemble more closely the meals of healthy persons, and are designed to promote nutritional health. Factors which must be taken into account when planning

the diet are caloric and protein requirements (special attention must be paid to growing children and obese patients), individual food habits, the severity of the diabetes, and the need for insulin. The variety of food included in the diabetic diet is particularly important, for these patients need foods that will offer an adequate supply of protein, vitamins, minerals and other essentials. Sugar, and foods prepared with sugar, are not recommended as this quickly absorbed carbohydrate makes too rapid a demand upon the crippled sugar mechanism of the diabetic. Diabetic specialty foods, which may be expensive, have no outstanding advantage over the natural foods which the diabetic is allowed to eat in the proper amounts. How the carbohydrate, protein and fat requirements will be divided through the day is a matter to be decided by the doctor and worked out by the dietitian.

Treatment with insulin is generally recommended if glycosuria persists after a reasonable trial period of diet. This trial period may range from a day to two weeks. However, many authorities believe that insulin should be given even in mild cases of diabetes. On this point Dr. Joslin says: "The use of insulin should be more widespread. I would stress its importance in the group with milder diabetes. The question is not 'Can you live without it?' because many can, and for some years; the point is that the patient with milder diabetes cannot afford to live without insulin. It is not 'Must you take insulin?,' but 'You ought to take insulin. Your comfort in the future depends on it.'"[2]

Today there are four types of insulin commercially available: amorphous or crystalline preparations of unmodified insulin, globin zinc insulin, protamine zinc insulin and NPH insulin. All of these insulins, discussed in *Drug Digest*, p. 46, restore the diabetic patients' ability to burn glucose and to store glycogen in the liver. When administered at suitable intervals, therefore, insulin helps to maintain the blood sugar within normal limits and keeps the urine free of sugar. Moreover, because this hormone contributes indirectly to the proper oxidation of fat, the ketone bodies or products of incomplete fat oxidation—acetone, diacetic acid and B-hydroxybutyric acid—do not appear in the urine, and the danger of diabetic acidosis and coma is eliminated. It is reported that one insulin unit promotes the metabolism of about 1.5 Gm. of dextrose.

Hypoglycemic reactions, the result of an abnormally low blood sugar, are characterized by faintness, palpitation, headache, double vision, stupor, hunger, trembling, unsteadiness of gait or excessive perspiration. Such reactions may be caused by insulin overdosage, a delay in eating, a missed meal, or an unusual amount of exercise which tends to increase the efficiency of insulin and the body's utilization of food. Because the onset of the reaction may develop suddenly, the ambulant diabetic usually carries with him some form of soluble carbohydrate such as a lump of sugar or candy. He may also bear a card giving his [*Continued on page* 63]

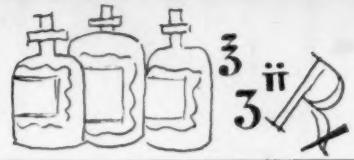
DRUG DIGEST

INSULIN INJECTION U.S.P.
(Hormone Therapy)

PRODUCT NAMES: Prepared by several pharmaceutical concerns
PHARMACOLOGY: Unmodified, or as it is sometimes called, regular or amorphous insulin is a purified aqueous solution of the antidiabetic principle obtained from the islands of Langerhans in the animal pancreas. Of the four types of insulin now commercially available for the treatment of diabetes, unmodified insulin produces the most transient and the most rapid effect. The action of unmodified insulin is evident in one hour, reaches its peak in 3 to 4 hours, and lasts 6 to 8 hours. It is used to treat diabetic emergencies associated with surgery, acidosis and coma, and injuries and infections; as a supplement to injections of modified insulin in severe diabetes; for initial treatment of diabetes; for shock therapy; and malnutrition.
DOSAGE: Insulin dosage will depend upon the individual diabetic patient's requirements as indicated by urine and blood sugar tests. Unmodified insulin is injected subcutaneously 30 minutes before meals; half the daily dose may be given before breakfast and half before supper. In more severe cases insulin should be injected before each meal. In diabetic emergencies insulin may be given intravenously. Insulin is commercially available in 10 cc. vials as a solution of the amorphous hormone or as a solution prepared from zinc-insulin crystals for allergic patients.
UNTOWARD ACTIONS: Insulin overdosage is marked by weakness, fatigue, tremulousness or nervousness and profuse sweating which may be followed by mental disturbances and unconsciousness. These symptoms are treated with soluble carbohydrates by mouth or by stomach tube. I.V. injections of dextrose are given to comatose patients. If dextrose solution is unavailable, a subcutaneous injection of epinephrine solution 0.3-0.6 cc. may be used, followed by oral carbohydrate.

GLOBIN ZINC INSULIN INJECTION U.S.P.
(Hormone Therapy)

PRODUCT NAMES: Globin Insulin with Zinc
PHARMACOLOGY: Globin zinc insulin, an aqueous solution of insulin modified by the addition of zinc chloride and globin—a derivative of beef blood—is an intermediate-acting insulin preparation. It takes effect in 1 to 2 hours, reaches its height of action in about 8 to 16 hours, and lasts from 16 to 24 hours. Although its effect may not be prolonged enough for daily one-dose control of patients with very severe diabetes, it has been used to advantage in the treatment of patients who require more than one daily injection of unmodified insulin, and diabetics whose blood sugar cannot be controlled by other insulin preparations. Frequently patients who exhibit allergic reactions to other types of insulin are able to tolerate globin insulin. Control of mild or moderately severe diabetes usually may be achieved with one daily injection. Like NPH Insulin and protamine zinc insulin, it is never recommended for the treatment of diabetic coma or other diabetic emergencies.
DOSAGE: Injections, which should be calculated for each individual diabetic, should always be made in the deep subcutaneous tissue—never intramuscularly or intravenously. Generally a single dose is given one-half to one-hour before breakfast, but when two injections are required, two-thirds of the dose is administered before breakfast, and one-third before the evening meal. Globin insulin should not be mixed with other insulin but may be supplemented by separate injections of other preparations. It is available in 10 cc. vials containing 40 units and 80 units per cc.
UNTOWARD ACTIONS: When globin insulin is given in too large dosage, reactions are most likely to occur about 8 hours after injection.



PROTAMINE ZINC INSULIN INJECTION U.S.P.

(Hormone Therapy)

PRODUCT NAMES: Protamine, Zinc and Iletin, Protamine Zinc Insulin

PHARMACOLOGY: Protamine zinc insulin is a milky suspension of insulin which has been modified by the addition of zinc chloride and protamine, a substance derived from the sperm or mature testes of fish. Classified as a prolonged acting insulin, protamine zinc insulin's effect becomes noticeable in about 6 to 8 hours, attains its peak in 12 to 24 hours, and lasts from 30 to 36 hours. Because of its slow absorption and prolonged action which prevents nighttime glycosuria, single daily injections have been successful in controlling many cases of diabetes.

DOSAGE: The dosage of protamine zinc insulin should, of course, conform to individual needs. A single subcutaneous injection consisting of not more than 40 units is usually given one-half to one and one-half hours before breakfast. If supplementary doses of unmodified insulin are needed, these may be administered separately or given in combination with protamine zinc insulin in the same syringe. In the latter event, two or three parts of unmodified insulin are generally mixed with one part of protamine zinc insulin. Protamine zinc insulin is supplied in 10 cc. vials containing 40 units and 80 units per cc. Before preparing the injection, the vial should be gently rolled in the palms of the hands to ensure adequate mixture.

UNTOWARD ACTIONS: As in the case of NPH Insulin, hypoglycemic reactions do not occur as frequently as do those resulting from the use of unmodified insulin but they may be prolonged and recurrent. Since symptoms are much less noticeable they must be anticipated and carefully watched for. If the patient shows symptoms, soluble carbohydrate should be administered immediately.

NPH INSULIN

(Hormone Therapy)

PRODUCT NAMES: NPH Iletin, NPH Insulin

PHARMACOLOGY: Like other insulin preparations, NPH Insulin, a combination of protamine and zinc insulin crystals, reduces the concentration of sugar in the blood and urine. Its value in the control of diabetes mellitus can be attributed to its stability, and to the fact that it combines much of the rapid effect of unmodified insulin and the prolonged effect of protamine zinc insulin and is therefore adapted to the requirements of the majority of diabetic patients. Its action generally is evident about 2 hours after administration, reaches its peak in 7 to 11 hours, and lasts from about 28 to 30 hours. Primarily indicated in the management of patients with moderate and severe diabetes who require more than 30 to 40 daily units of protamine zinc insulin, this relatively new compound usually simplifies treatment by cutting down the need for supplementary injections of unmodified insulin and mixtures.

DOSAGE: This insulin, which is available in 10 cc. vials containing 40 units and 80 units per cc., is always administered subcutaneously in accordance with individual requirements determined by frequent urine examinations and blood sugar estimations. Before filling the syringe, the contents of the bottle should be thoroughly mixed by gently turning the bottle from end to end several times.

UNTOWARD ACTIONS: Although hypoglycemic reactions are less obvious than those resulting from overdosage of unmodified insulin, they may be more prolonged and recurrent. Early symptoms of fatigue, drowsiness, tremulousness call for prompt ingestion of a soluble carbohydrate—candy or orange juice—followed by more slowly absorbed carbohydrates such as crackers and milk. I.V. dextrose injections are given to combat severe reactions.

Credit Union officers study educational and promotional literature on credit unions

A Professional Nurses' Credit Union

by Florence Thorson, R.N. and Mary Tillman, R.N.

■ ONE FRIDAY EVENING an officer of the Professional Nurses Credit Union of St. Paul and Minneapolis received an emergency call from a nurse who had just learned that her mother in Alabama was critically ill. She wanted to leave on the earliest possible plane in order to help with nursing care and expenses, but she was short on cash and the banks were closed until Monday. Could she please have a loan?

Since one of the characteristics of the Credit Union is action rather than red tape, the answer was soon forthcoming. Although the nurse had no account with the association, the officer asked the superintendent of nurses at her hospital and some others to co-sign a Credit Union loan of $500, and before too many hours had passed she was off on her mission.

This is but one of the many instances in which the Credit Union of Minnesota's Twin Cities has helped some deserving nurse over a financial hump. The loan files are bulging with other cases—some dramatic and some merely routine. But no matter how different the circumstances surrounding the loan, all have two things in common: the profession of nursing and the need for financial aid.

The origin of this unique savings and loan institution dates back to 1938 when a small group of private duty and general duty nurses decided that nurses needed special help with their financial affairs. It seemed to them that the credit union set-up used by postal employes and other employe groups would best serve this purpose. Accordingly, they applied to the State Banking Department for a charter to establish what is known now as the first official Credit Union

for professional nurses in the U.S.

The credit union movement itself is over a hundred years old. In this country it received much of its impetus from the support of Edward Filene, the famous Boston merchant. Today, more than 10,000 credit unions in the U.S. claim over three million members. As one of the 10,000, the Twin Cities Nurses Credit Union, which belongs to the state and national credit union associations, is limited in its charter with the State Banking Department to residents of the Twin City area, in the belief that a credit union is most apt to succeed where its members have close bonds.

Operating under state banking supervision, the Nurses Credit Union, like all other credit unions, supplies its members with three basic services: a convenient system for accumulating savings; a source of credit at normal interest rates; and education in the proper management of money through budget counseling, educational literature and other methods.

As a thrift plan, the Credit Union is most interested in the individual who can save the least, therefore it encourages small deposits; the ceiling on savings is placed at $2,500. Any amount of savings up to $1,000 is automatically doubled at the nurse's death, thus providing some income for a beneficiary at no cost to the saver.

The earnings on savings is high. Because all of the savings shares are used for loans which bring in interest, the association has been able to pay 3 and 4 per cent on savings for the past few years. Thus far, there has been about one borrower for every saver.

In contrast to unethical loan concerns, credit unions recognize that the average man or woman is honest; that usurious money lending has no place in modern economic life. A nurse may borrow $50 from the Union on her signature. When this is paid back she may borrow $200 more. To obtain a loan over $200, however, she must have a co-signer or show some security, and she cannot borrow over $1,500.

Personal loans are granted at an interest rate of only 1 per cent per month on the *unpaid balance*. Car loans are $4 per $100 per year. At the present time, the Union is prepared to grant car loans up to $1,500, since it considers the mortgage to be sufficient collateral. Interest paid on loans provides for educational literature, running expenses of the association, insurance payments to the national credit union agency, CUNA, and dividends to share savings holders.

Since all loans are insured, they are cancelled paid in full in case of death or total disability of the borrower. It is to the nurses' credit that in the 13-year history of the agency there have been no outstanding failures in meeting payments. Nurse borrowers are not only honest, but because they realize that they are using other nurses' hard-earned money they seem to make a special effort to meet their obligations.

All of the Credit Union loans are granted for "provident and productive" purposes such as automobile financing, in- [*Continued on page* 78]

THE RED ✚ CROSS adopts

● To start the cycle the operator places his hands on the victim's back so that the thumbs just touch and the heels of the hands are just below a line running between the armpits.

● He then rocks forward slowly, keeping the elbows straight, until both his arms are approximately vertical, exerting steady pressure on the chest to expel air from the lungs.

A new technique of artificial respiration which permits a greater exchange of air in the victim's lungs will replace the prone pressure or the Schafer method used in first aid training, according to an ARC announcement. Said to be easier to teach and to perform, the procedure has been adopted by the armed forces, the USPHS, the AMA's Council of Physical Medicine and Rehabilitation

new lifesaving technique

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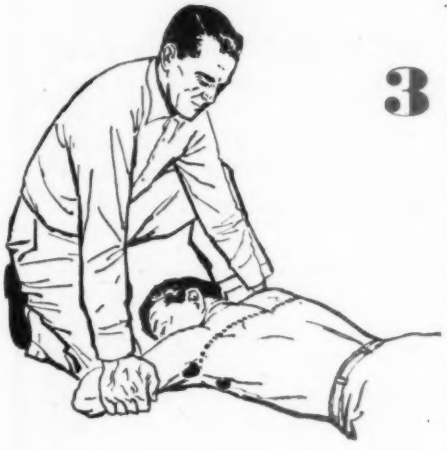


3

● Then the operator rocks back to the kneeling position slowly sliding his hands to the victim's arms just above the elbow, thus getting ready for the next phase of the procedure.

● Continuing to rock backward, he raises the arms until resistance and tension are felt at the victim's shoulder. Then he drops the arms. The cycles are repeated 12 times per minute.

and other organizations. The system is already standard in Europe. Correct positions for the back pressure-arm lift method are here illustrated. The victim is placed face down with the elbows bent and with one hand upon the other. The cheek is placed on the hand with the face turned slightly to one side. The operator kneels on one or both knees at the head of the victim.

REVIEWING THE NEWS

▶ RURAL NURSING is being stressed at Emory University, Georgia, where one month's clinical experience in hospitals outside the metropolitan areas will be offered to students who are candidates for a B.S. in Nursing. The program, made possible by a Kellogg Foundation grant, is similar in scope to that provided by the Emory University School of Medicine which allows senior students to spend one month in training with a country doctor. Both projects are aimed at extending services to rural areas and decentralizing medical care. Six possible rural centers will be named this year, from which three will be selected to begin the new project.

▶ THE MASCULINE VERSION of nurses aides—spelled aids—can be found at St. Joseph's Infirmary in Atlanta, Ga., where a two-month training program for men has been instituted. The students, who receive practical experience as well as some theory, are paid a salary of $75 a month. To be eligible for the course, they must be between 18 and 35 years of age and have a high reference rating.

▶ A STRONG BOOST for voluntary prepayment medical and hospital plans and consequent de-emphasis on compulsory health insurance may result from a decision of the Wage Stabilization Board. Employers may be allowed to pay 100 per cent of workers' premiums for hospital and medical-surgical coverage, and up to 60 per cent of the cost of family protection. Under the liberal provision, WSB approval is not required for employer-paid enrolment in hospital plans providing benefits are similar to those of Blue Cross. The new ruling —certain to be approved—means that organized labor will undoubtedly press for inclusion of these "fringe benefits" in future contracts.

▶ A $31,202 GRANT for a program in advanced psychiatric nursing during 1951-52 will be administered by Duke University's Division of Nursing Education under the directorship of Louise Moser. Designed to encourage more young people to enter mental health work, the Duke program prepares graduate nurses for work as head nurses in psychiatric units of hospitals, child guidance clinics and other health centers. The training facilities for the nurses taking the course include Duke Hospital, North Carolina State Hospital in Raleigh, Highland Hospital in Asheville and community agencies.

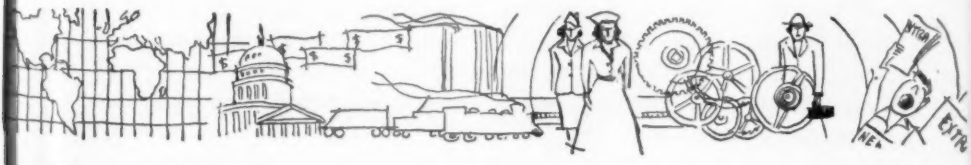
▶ DUPLICATION of health services is avoided in North Arlington, N. J., where the local health department with its complement of three nurses assumes responsibility for the health of children from the prenatal period to high school graduation. This integrated set-up, the only one of its kind in New Jersey

and one of eight in the nation, provides intelligent follow-up care and saves taxes by eliminating the need for a separately financed school health program.

▸ POLIO PARLEY: Sixty nurse representatives from the NFIP, ARC, ANA and Joint Orthopedic Nursing Advisory Service (JONAS) met in New York City, November 26-27, to discuss ways of coordinating polio nursing services and effecting economies in patient care. The joint conference called by the National Foundation for Infantile Paralysis which faces a current $5 million deficit, elicited the following suggestions: state and local polio planning committees which would determine what could be done in an epidemic and how local facilities could be utilized; special polio training by supervisors for staff nurses; emphasis on polio nursing in the nursing school curriculum; and one standard for isolation techniques. Factors which have inflated polio expenses were reported to be payment of communicable disease rates to nurses caring for polio patients, an unnecessarily long period of isolation in the hospital, and poor use of community resources. Far too often, it was charged, hospitals ask the Red Cross to import nurses when local nurses might be available for at least part-time duty . . . The National Foundation has recently announced a salary increase for recruited polio nurses. Locally recruited nurses are paid prevailing private duty rates for *general staff nursing* plus one meal allowance, if such allowance is customary in the district. Nurses recruited from outside communities receive $275 per month, and maintenance up to $100 per month; recruited supervisors are paid $300 per month.

▸ THE FIRST STATEWIDE organization of future nurses is the claim of Future Nurses of Michigan, which adopted its constitution in November, 1951. Over two hundred girls, representing about 80 Future Nurses Clubs in high schools, attended the meeting which marked the beginning of the Association, and resulted in approval of a resolution "to do all we can to recruit more nurses."

▸ WASTE, INEFFICIENCY and poor management are the charges leveled against New York City's hospital system by a management consultants' report. The four-volume, 685-page report states that the Hospitals Department could save $14,313,081 a year plus $50,900,000 in a long-range construction program if certain reforms were instituted. Among the 98 recommendations listed are: collection of unpaid hospital bills; barring hospitalization to non-indigent patients; removing custodial-



type patients to convalescent and nursing homes; and charging employes the actual cost of food they consume. Also called for were steps to halt absenteeism, particularly among nurses. To help meet the serious shortage of nurses—3,594 as against 6,778 authorized for the Department—the report approves previous plans to shorten nurses training from three to two years, establish more training schools and utilize more practical nurses. In an angry rejoinder to the survey's findings, Dr. Marcus D. Kogel, Commissioner of Hospitals, indicated approval of recommendations on organization and management, but took a dim view of the survey consultants' opinions on medical administration. He placed much of the blame for the evils in the hospital system on the Budget Director and outmoded methods of hiring employes.

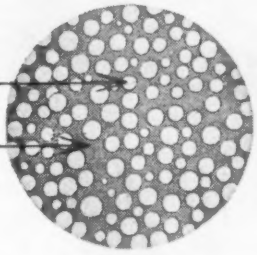
►NEWSLINGS: Under a new anti-discrimination policy Negro girls may now enter the University of Oklahoma school of nursing, provided they pass the entrance examinations . . . Founder members of the newly organized New York State Association of Industrial Nurses elected the following officers at their recent meeting in Syracuse: President, Ella Casey, New York City; first vice-president, Helen Coates, Rochester; second vice-president, Mrs. Emmaline Oswald, Syracuse; and treasurer, Cecile Monette, New York City . . . Alaskan nurses may now join the Alaska Nurses Association, an organization founded on May 19, 1951. The next annual meeting will be held at Seward, Alaska, May, 1952 . . . Since April 15, 1951, when New York City private duty nurses began their campaign to receive $12 a day in addition to meals, nearly all private and 15 voluntary hospitals have acceded to demands.

►A CIVIL DEFENSE REPORT, prepared by the Committee on Emergency Medical Care of the American Diabetes Association, which appeared in the *JAMA*, urges an educational and training program for diabetics and for civilians who may have to care for diabetics, in order to prepare them for a major disaster. The article points out that since 70 per cent of the diabetics in the U.S. take insulin, many would die in a short time if insulin were not available. Furthermore, it is stated that in the event of a disaster, many diabetics who do not now need insulin would require it as a result of injuries, burns or shock. As part of the total manpower reserve, diabetics are termed invaluable as auxiliary helpers because of their facility in giving hypodermic injections.

►ANA HIGHLIGHTS: The Studies of Nursing Functions' program for which the ANA has received more than $90,000 has made its first grants for studies to six states . . . By November 30, 1951, there were 1,671 associate members listed at ANA headquarters. Associate membership, a new type of ANA membership, is now available through 28 SNA's . . . The ANA's [*Continued on page* 84]

Q. **What is the advantage** of a discontinuous film of protection in baby skin care?

A. **The principal advantage** of the discontinuous film of protection is that it allows the infant's skin to "breathe" and function normally. This important feature of Johnson's Baby Lotion was achieved by creating an emulsion-type lotion consisting of droplets of oil homogeneously dispersed in water.



(Diagrammatic)

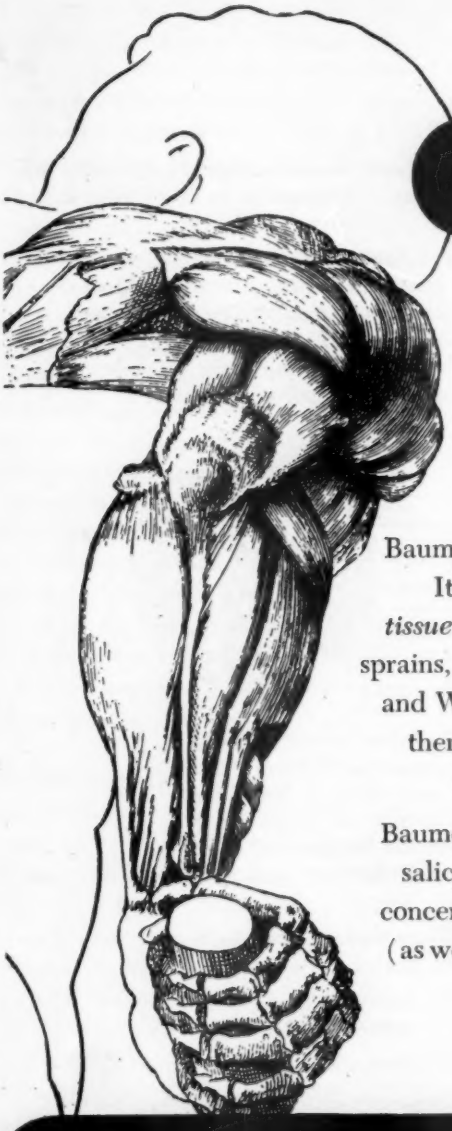
When this preparation is placed on the infant's skin, minute interstices—as shown in the accompanying diagram—are formed between the oil droplets by evaporation of the water phase of the emulsion. *Thus, a thin layer of the lotion forms a discontinuous film which affords protection but does not block the transpiration of water vapor, or interfere with other metabolic functions of the skin.*

In addition to this important physiologic feature, Johnson's Baby Lotion has these distinct advantages:

1. Contains hexachlorophene (1%), an antiseptic that exerts prolonged suppression of the resident bacteria of the skin.
2. Contains no ingredients likely to sensitize the skin.
3. Possesses both prophylactic and therapeutic action against the most common skin affections of infancy.
4. Exerts powerful buffering action which neutralizes both excessive acidity and alkalinity.

JOHNSON'S BABY LOTION

Johnson & Johnson



going deep

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Baume Bengué

ANALGESIQUE

1. Lange, K., and Weiner, D.: J. Invest. Dermat. 12:263 (May) 1949.

Thos. Leeming & Co. Inc. 155 E. 44th St., New York 17, N.Y.

Talking of Taxes

[*Continued from page* 32]

ity tax the resultant computation is a little more complicated. Basically, only the first $3,600 total amount of such salary and income is subject to any social security tax.

Here are some examples explaining the computation.

Net Self-Employment Income	Employe's Salary, Soc. Sec. Tax Withheld	Total Earnings	Amount Subject to 2¼ Per Cent Tax
Under $400	Any amount	Any amount	None
$500	$3,000	$3,500	$500
$500	$3,600 or +	$4,100 or +	None
$3,600 or +	None	$3,600	$3,600
$2,000	$2,000	$4,000	$1,600

Joint Returns of Husband and Wife

The whole idea of the joint return is that husband and wife combine their separate incomes, deductions and exemptions on one tax return. In computing the tax the joint income subject to tax is cut in half, and the tax rates are applied to half the income. The tax thus determined is then multiplied by 2 to give you the total tax. This procedure generally results in a lower total tax because the tax rates go up quickly as income increases. For example, suppose that after taking off deductions and exemptions you had income subject to tax of $2,000 and your husband had $6,000. If you filed separate returns, your tax would be $408 and your husband's would be $1,396, total $1,804. If you filed a joint return the total tax would be $1,712 (tax on ½ of $8,000 x 2) or a $92 saving.

Normally, a joint return must be signed by both spouses. If you were married on or before December 31, 1951, or if your husband died during 1951 and you haven't remarried, you can file a joint return. Common residence is not required for filing a joint return. If you were legally separated or divorced on or before December 31, 1951, you must file a separate return. There is no proration to be made because of any change in status during the year.

Which Tax Form to Use

It depends on the amount and type of income and deductions for yourself (and your husband). The simplest method may be the costliest for you; study your own situation first; try all the methods available in your case and use the one that produces the lowest tax.

Form 1040A is the simplest type of return on which you answer questions as to your income and exemptions. From your answers the tax collector computes your tax, mails you a bill or sends a refund. In computing your tax the Collector will automatically allow you a standard deduction of about 10 per cent of your total reported income.

An unmarried R.N. whose total income is less than $5,000 consisting of salary subject to withholding and less than $100 of dividends and interest will generally use Form 1040A provided her deductions are less than 10 per cent of her income. Form 1040A cannot be used if your income exceeds $5,000 or if you were "in business" as a private duty nurse, or if you had more than $100 of dividend or interest income, or if you had rent

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MEDICAL SERVICE

or other miscellaneous income, or if your husband files a separate return and itemizes his deductions. Don't use Form 1040A if, as an employe, you incurred travel expenses away from home overnight on your employer's business. Finally, avoid Form 1040A if actual deductions exceed 10 per cent of your income.

The second possible form to use is called "Short Form 1040," called "short" because you look up your tax on the table on page 4 and then tear off pages 3 and 4 of the form before filing the return. This form can be used if your "adjusted gross income" is less than $5,000, and should be used if your actual deductions are less than 10 per cent of your "adjusted gross income." After figuring out your "adjusted gross income" and "exemptions" just look up the tax on the table on page 4 of the return. For example, if your adjusted gross income is $2,455 and you have 1 exemption, your tax, as shown on the table, is $330. The tax table on page 4 automatically allows you a "standard deduction" of about 10 per cent of your "adjusted gross income."

You can use "Short Form 1040" as a joint return; however, if your husband files a separate return and itemizes his deductions you are prevented from using "Short Form 1040."

The third and final type of return is called "Long Form 1040," called "long" because you leave all 4 pages intact, either itemize your deductions or take a standard deduction, and actually compute your own tax rather than look it up on a table.

This form must be used if your "adjusted gross income" is $5,000 or more. On this form you can itemize your actual deductions or you can take a standard deduction of exactly 10 per cent of your adjusted gross income ($500 limit on a married person's separate return). If your husband files a separate return and itemizes his deductions, you are required to itemize your deductions rather than take a standard deduction.

As a general rule, if you have actual deductions exceeding 10 per cent of your adjusted gross income, elect to itemize your deductions on Long Form 1040. Consider an R.N. claiming one exemption, having adjusted gross income of $2,350, actual deductions of $350. Here are her comparative taxes: If she does not itemize deductions—$311. If she itemizes deductions on Long Form 1040—$285.60.

That's the tax story in brief. It is hoped that the preceding pointers will make your tax chore easier.

Taxes pay for the babies in Sweden. Dr. Birger Lundquist of Sweden, visiting this country, said that the Swedish Government "not only pays all expenses for medical and hospital care when a baby is born, but there are in addition several forms of financial aid to expectant mothers. Midwives handle all deliveries in Sweden, even in the hospitals. The cost for the education of midwives has been assumed by the Swedish Government since 1723. About 90 per cent of all deliveries are in hospitals and 10 per cent at home."

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The Florists' Telegraph Delivery Association is proud to have a share in making many of these girls' dreams come true. For, FTDA members contribute yearly to a Fund used for Nurses' scholarships and aid. Last year, for example, FTDA members gave $50,000 toward this Fund in ceremonies such as the one illustrated, where Mr. Victor Stein of FTDA presents a check to the President of the San Francisco Hospital Association. This past year saw almost 700 young women training on FTDA scholarships for this, the Proudest Profession.

FLORISTS' TELEGRAPH DELIVERY ASSOCIATION,
Headquarters: Detroit, Michigan

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R.N. Speaks:

[*Continued from page 27*]

professional organizations have faced this obstacle. What have they done about it? Constituent members of the National Education Association, the American Association of Social Workers, and the American Library Association—all in the same approximate income bracket as professional nurses—have adopted a system of graded or graduated dues. Not only do these associations provide for graduated dues, but two also allow installment payment of dues when it is deemed necessary.

Chapters of the American Association of Social Workers in New York City, Cleveland, Chicago and Los Angeles utilize a sliding scale based on a salary range for junior, full, associate and emeritus membership. The national dues are $12.50. In Los Angeles, a social worker making less than $2,400 a year pays $12 annual chapter dues; when her salary increases to $3,000 a year, she will pay $16 chapter dues, and so forth. In New York City, where the state dues are higher, $30 a year would be paid on a salary of $6,000 or more.

The Arizona State Education Association collects all dues, state and national, allowing its members to pay half or more at the time of enrolment—usually in the fall—and the rest in February. Its dues, on a sliding scale, start at $10 a year and go up to $29.50. Also, the American Library Association offers individual and institutional membership, paid on a sliding scale. The individual earning $2,100 a year pays $3 a year national dues; on $4,000 or over, $10 a year is paid. The libraries or library schools pay according to their income for the year. Interestingly enough, all these professional associations include a national and/or state publication with the payment of dues.

Is it not more professional to woo new members with a system of graded dues than with trophies, awards and free candy bars (the latter tried in one state recently)? Is it not a tenable supposition to believe that nurses in the higher paying positions are more able to pay higher dues than are nurses in the lower income brackets? For example, will not a director of nurses, making a salary of $6,000 a year, be more apt to be in a better financial position to pay $25 a year to the ANA than will a private duty nurse making $2,600 a year be able to afford $5 national dues—when that $5 is superimposed on possibly $32 a year for both state and district dues, and $60 annual registry fees?

Just in time to strengthen our own conviction comes a report from the West Virginia State Medical Association that provisions can be made for members to request waiver of the AMA $25 annual dues on grounds of financial hardships. Need we mention the disparity between the salaries received by doctors and nurses?

The ANA bylaws will be brought up for revision at the Biennial. To our way of thinking this system of graduated dues is worth investigating and should be put on the agenda for house of delegates' consideration.

—Alice R. Clarke, R.N., Editor

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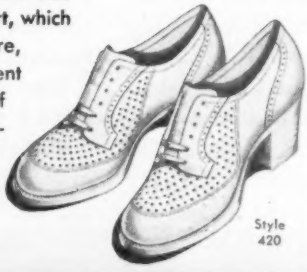

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Diabetes

[*Continued from page* 45]

name and his home address as well as those of his physician, and the legend: "I am a Diabetic (I am not intoxicated). Place sugar or candy in my mouth, but if this fails to revive me in 15 minutes, call my physician or send me immediately to a hospital." To avoid such diabetic catastrophes in the hospital, nurses should check insulin dosage several times to ensure administration of the correct number of units. The same degree of care is necessary to eliminate the dangers resulting from underdosage.

One of the most serious complications of diabetes is diabetic acidosis and coma resulting from neglect of treatment, underdosage of insulin, or conditions such as acute infections, surgical operations, and thyrotoxicosis which may aggravate the diabetic state. Acidosis is caused by the presence of ketone bodies or acids which combine with fixed bases and use up the alkali reserve of the body. As the normal alkaline reserve is reduced, the CO_2—combining power of the blood is lowered, leading to the characteristic labored breathing, air hunger with deep inspirations or Kussmaul's respirations. Other significant symptoms and signs include: headache, malaise, anorexia, nausea and vomiting, abdominal pain, constipation, fatigue, drowsiness and mental torpor, prostration, coma, signs of shock, odor of acetone on the breath, dry skin and mouth, and soft eyeballs.

Hospitalization and special nursing care are indicated for the patient who is in coma or approaching coma. Bed rest and warmth are essential, but hot water bottles should *never* be used to supply this warmth. In addition to insulin injections and the I.V. infusions of saline, dextrose, sodium lactate or sodium bicarbonate which the doctor may order, it may be necessary, in the event of extreme collapse, to give blood transfusions and cardiac stimulants. As soon as possible, fruit juice, ginger ale, tea, broth or gruel should be administered by mouth. The amount and type of insulin given these patients after they recover from the acute state will, of course, depend on the individual patient's needs.

Perhaps the major problem facing researchers in diabetes today is that of vascular complications. Although insulin has significantly extended the life of diabetics, it has not seemed to prevent the occurrence of degenerative vascular changes in the brain, heart, kidneys, the retina of the eye, or the extremities where impaired circulation often leads to gangrene. These all too common vascular disturbances, considered by many to be the result of inadequate control of diabetes, appear to be related to the duration of the disease rather than to the patient's age. Thus a young adult may have the tortuous arteries of a man twice his age, and young diabetic women may be unable to bear living children because of their calcified pelvic arteries.

In the case of diabetic pregnancies without advanced vascular disease, a fetal survival rate of 90 per cent has been attained by Dr. Priscilla White, who has evolved a special regimen in-

volving hormone therapy for her pregnant diabetic patients. Nevertheless, Dr. White adds that: " . . . only when the genetic and vascular problems of diabetes are solved will the diabetic obstetric experience be equal to the best in non-diabetic obstetric experience."[3] It can be seen, however, that pregnant diabetic women should always be under a doctor's care.

According to Dr. Glenn Shepherd of Kansas City, you may cause the diabetic to "leap from the organic frying pan into the psychological fire" if too much stress is laid on meticulous weighing of food, numerous blood sugar tests and multiple insulin injections.[4] In his opinion, dangerous self-absorption can be avoided and cooperation obtained if you make it clear that you are working toward the goal of a nearly normal life. In helping the new diabetic to adjust to his disease it is necessary for the nurse to present instructions in a clear and understanding manner. Often the patient is considerably shocked by the doctor's diagnosis, and it will take a while for him to absorb the details of insulin administration and diet; the hygienic measures he must take to avoid infection; and all the *do's* and *don't's* that accompany diabetes. Reassurance, and the enlistment of voluntary cooperation are of major importance in promoting a successful diabetic program.

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[1]American Diabetes Association, 11 West 42nd St., New York 18, N.Y.
[2]*JAMA*, June 18, 1949, p. 582.
[3]*Modern Medicine*, June, 1949, p. 76.
[4]*Kansas Medical Journal*, June, 1949, p. 271.

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Nursing in Ohio

[*Continued from page* 39]

that the proposed law was dangerous since it gave control of the profession to the male members of the state medical board. The relationship between the state medical board and the nurses proved so amicable, however, that it was not until 1941 that a state board of nurses was officially created.

From the evidence presented in the book, it is clear that Ohio has taken a somewhat different view toward the national nursing organizations than have some of the other states. One of the most controversial issues in Ohio has been whether nursing education should be the concern of a state section on education or a state league of nursing education associated with the National League of Nursing Education. Although efforts have been made to have the state league recognized by the state nurses association, at present, both the OSNA section on nursing education and the Ohio State League exist "with an obvious duplication of program and effort." A similar attitude was taken toward the NOPHN as early as 1917, when the public health group voted to become the section on public health nursing of the state nurses association. According to the authors, "The basic objection of Ohio nurses to both the NLNE and the NOPHN is the fact that these groups accept lay members and place a greater emphasis upon the improvement of nursing services than upon the advancement of the professional nurse." They quote one Ohio leader

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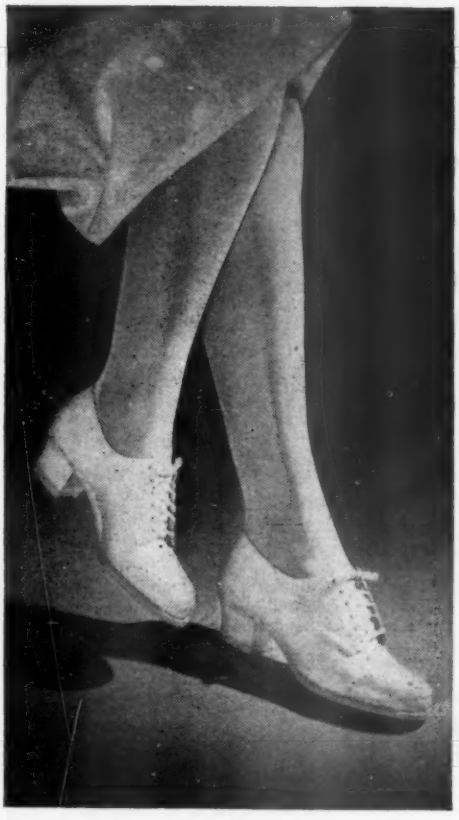

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First, **remember moisture and perspiration deteriorate both leather and shoe fabrics. Own two or more pairs and change daily. Let one pair air and dry while wearing another.**

Second, **use form-fitting shoe trees—your shoes will hold their graceful shape longer.**

Third, **shoes should be cleaned off the feet so they will dry rapidly and thoroughly.**

Fourth, **be sure your shoe cleaner is absolutely safe. Griffin Allwite is neither alkaline nor acid, but absolutely neutral and will not harm leather, streak, discolor or give a painted, artificial look. More nurses and beauty operators use Griffin Allwite than any other white shoe cleaner because it makes shoes look fresher and more beautifully white than new, covers spots and worn places and cleans as it whitens. For white shoes at their smartest, use Griffin Allwite.**

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GRIFFIN ALLWITE

who described both proposed structure plans as nursing service plans and warned against the loss of professional identity and control if either were adopted.

Generalizations are always dangerous, particularly when made about an organization consisting of some 11,000 nurses with varying opinions and viewpoints. Nevertheless, it appeared to this reviewer that the Ohio State Nurses Association, as presented in the pages of *Nursing in Ohio,* emerges with certain characteristics, perhaps the most distinctive being an independence of thought and action and a strong belief in state's rights; characteristics consistent with the political climate of Ohio, a state which still retains a goodly amount of Midwestern individualism.

According to the authors of *Nursing in Ohio,* anti-discrimination policies, as far as nursing is concerned, made slow headway until recent years. In 1947, only one Ohio school admitted Negro students; in 1948, however, it was reported that 13 schools were accepting Negroes. Because of membership restrictions, Negro nurses formed their own professional association, the Buckeye State Nurses Association, which was disbanded in 1951 as a result of more liberal membership policies. Today there is only one district association which denies equal membership to Negro nurses.*

In examining the book from a critical point of view, one can say that the Rodabaughs have, in general, organized their material well, and have presented it in an interesting manner. They appear at their best, however, in the first part of the book where they are more concerned with recording historical events than they are with interpretation. Particularly disconcerting is their habit of injecting editorial comment on important issues. At the end of an excellent chapter on public health nursing, for example, one finds this statement " . . . the humanitarian spirit which once motivated the nursing profession seems to be wilting. The materialism of the country today, the ruthless drive of the profit motive, and other

*No mention is made of Ohio district membership laws which have allowed two negative votes to keep potential white or Negro members from joining the district—one of the facts brought to light at the 1950 Biennial.

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factors which have weakened the moral fibre of our people and our political leaders have taken their toll among the nurses. They are at work in general to make money." Although this statement is modified, such "editorializing" does detract from the historical intent of the book.

In their discussion of the college versus the diploma program in nursing education, the authors state that it is "probable" that eventually a college education will be demanded of all registered nurses. They state that the "three-year diploma nurses training school is being limited to the production of bedside or general duty nurses who have less and less opportunity for advancement in their profession as the college programs graduate more nurses." In the next sentence, however, they write that "most young women in Ohio, given the choice between the college and diploma programs, are choosing the latter." In this instance, the authors appear to magnify the trend toward collegiate nursing education more than the actual facts in Ohio would justify.

However one might quarrel with some of the Rodabaughs' assumptions, no one can deny that both they and the Ohio States Nurses Association have made a significant contribution to nursing. More state nurses associations should follow Ohio's lead in adding to our all-too-small store of recorded professional history.

—BY FRANCES LEWIS, R.N.

Nursing in Ohio may be obtained from the Ohio State Nurses Association, 904 E. Broad St., Columbus 5, Ohio. The price is $4.00 postpaid.

All Children Can Benefit from *this* Protective Hot Drink at Breakfast

In its widely distributed leaflet No. 268, "Eat a Good Breakfast," the U. S. Dept. of Agriculture states: "Summer or winter, there's something hot, as a rule, in a good breakfast. . . . Something hot is cheering and tones up the whole digestive route."

The problem of encouraging children to eat an adequately protective breakfast finds easier solution when Ovaltine in hot milk is recommended as a breakfast beverage. Many children clamor for a hot drink at the morning meal, and hot Ovaltine is the right kind of drink to recommend.

A cup of hot Ovaltine makes an excellent contribution of virtually all essential nutrients, adding substantially to the nutritional start for the day. It also serves in a gustatory capacity by enhancing the appeal of breakfast and making other foods more inviting.

The nutrient contribution made by a cup of Ovaltine is apparent from the table below. Note the wealth of essentials added to the nutritional intake by making the simple recommendation of adding a cup of hot Ovaltine to the child's breakfast.

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PHOSPHORUS	315 mg.			CALORIES	225

*Based on average reported values for milk.

Candid Comments

[*Continued from page* 34]

within the profession of nursing. The nurse, proud of her uniform, her cap, her profession, doesn't find it easy to work side by side with untrained people, clothed in the same identifying garb, who get almost the same pay, and who sometimes try to tackle assignments that make the blood run cold.

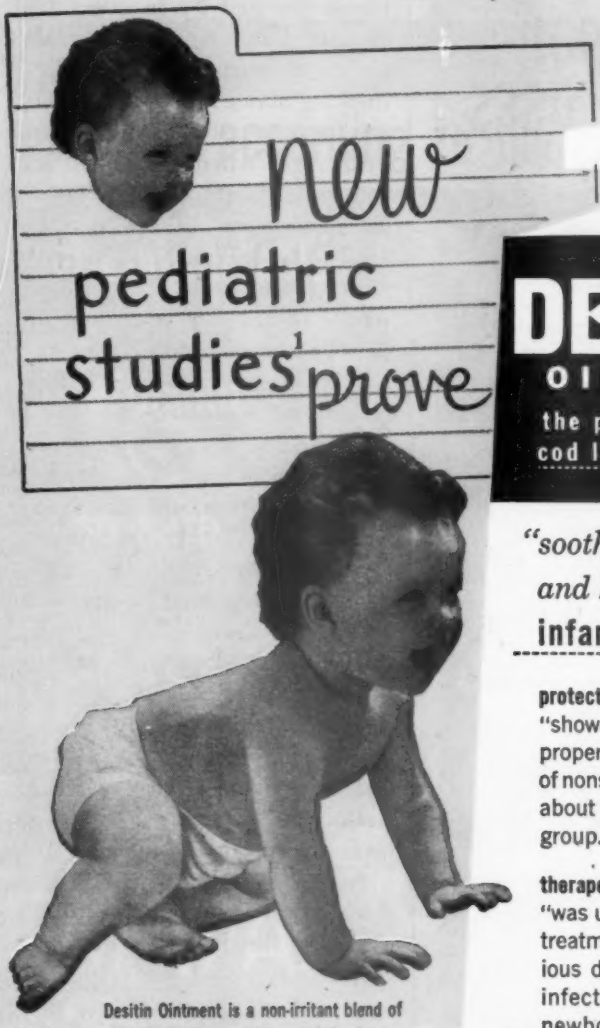
The profession is working hard on these inequities, but they cannot be ironed out without the support of doctors and hospital administrators. It's also to their advantage to help, and in numerous instances we are getting this support. More and more our professional publications report team-nursing experiments, and inter-staff conferences in developing total cooperation in protecting patient care. But in too many other instances we get actions that turn the nursing job into a veritable jungle. Nursing is too important in community welfare to permit proved standards to be juggled about by an unknown number of uncooperative, uninformed, unprofessional people.

The situation today calls for more positive, planned action by nurses in maintaining the profession's place in determining the lines of demarcation in the nursing function. It's never been so important for us to create avenues by which we can establish better understanding and cooperation with our allies. Too often we're put on the defensive, when we should be the aggressors. The nurses of a single hospital, taking the lead, may or may

not get results, but our professional associations have both power and prestige that could be utilized. A district association, for example, for taking up the issue of safe nursing care objectively and forthrightly, isn't as easily rebuffed as a single group, especially if the public is informed.

We have an especially important task of working more closely with the doctor. Every good nursing act helps him—every poor one hurts him, whether or not he is aware of the fact. We're as interdependent as the fingers on a hand. But how many doctors actually know what ingredients go into good nursing? And how many nurses know what goes into good doctoring? The difference is that more doctors than nurses *think* they know the other side, and therefore become judges of all that nursing encompasses. Some men are quite content to leave the job of nursing education and practice to the proper nursing authorities. There are others who are pretty sure they know what should go into the curriculum and who should do which nursing jobs, though nurse authorities are never so sure.

Instead of concentrating too much attention on the small segment that violates basic principles of patient protection, however, we should seek out and work with the much larger group whose ideals and purposes are equal to the best we offer. It is high time we developed more direct avenues for the exchange of ideas with our allies in medicine and in hospital administration. It would be pretty wonderful to see this happen through



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1. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediat. 68:382, 1951.
2. Behrman, H. T., Combes, F. C., Bobroff, A. and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.

committee activity in every unit of organized nursing. It's as profitable for us to learn what our allies are thinking about nurses and nursing as it is for us to tell them what we think. Years ago, when a medical society concluded that one year's training was all that any nurse needed, I managed to be appointed secretary to its nursing committee. The ensuing six weeks of hearing testimony of patients, administrators, doctors and nurses, as they appeared before the committee, was one of the most profitable and exciting periods of my life. The patience and open-mindedness of the committee impressed me greatly; I learned that doctors and administrators have legitimate complaints about nursing that nurses should know. But above all, I learned that nurses aren't alone in wanting only the best, the safest and the most productive care for patients. The committee did not recommend one-year training; instead it urged medical societies "to work with the nursing profession on this complex problem."

Nursing has come a long way from the days of being "an extra pair of hands for the doctor." As the profession has accepted the responsibility for the nursing care of our people, the position of nurses has changed from silent to active partnership. It cannot fulfill its purposes if any part of its rights to decision are abrogated by others. We ourselves must recognize the responsibilities of this broad role and take stronger steps to promote the understanding and cooperation of our allies that are essential to our plans for adequate patient care.

Credit Union

[*Continued from page* 49]

come taxes, rent, new electrical appliances, furniture, clothing, payment of dues and vacations. One young couple used their combined savings on a down payment for their new house, and as a result, could not afford much-needed furnishings. The wife, a nurse, borrowed $300 from the Nurses Credit Union and paid it back in six months with an interest outlay of only $9.67. It is also customary for students to borrow $50 on their signatures about one month before graduation in order to cope with uniform costs, room rent and general graduation expenses.

In many instances, nurses who have been taken in by loan sharks are helped to economic recovery by the Credit Union. One nurse whose expenses were getting the better of her budget, borrowed $300 from a loan company for which privilege she was required to pay $14 per month interest. Apprised of her plight, the Nurses Credit Union took over the obligation and the loan was paid back in six months. The nurse's monthly payments under the new plan were $50 plus 1 per cent interest and the total interest for the six-month period came to about nine dollars. Also, at no additional cost, she was covered by the standard insurance against death or total disability.

The backbone of the Nurses Credit Union in the Twin Cities is its roster of nurse officers who serve without pay. One of the most important officers is the bonded treasurer who

THE TRUTH ABOUT
FROZEN ORANGE JUICE

Significant Dietary Advantages Of Fresh-Frozen Minute Maid Orange Juice Over Home-Squeezed Orange Juice Shown By Independent Research

RECENT assays[1] emphasize the nutritional superiority of reconstituted Minute Maid Fresh-Frozen Orange Juice over home-squeezed orange juice in three respects:

a. **Average levels of natural ascorbic acid were significantly *higher* in Minute Maid;**

b. **Peel oil content was significantly *lower;***

c. **Bacterial counts were dramatically *lower.***

Two reasons for Minute Maid's higher ascorbic acid content are advanced:

First, oranges vary widely in ascorbic acid content.[2] Thus, whole oranges squeezed a few at a time provide a highly erratic source of Vitamin C. Each can of Minute Maid, however, represents the pooling of juice from hundreds of thousands of oranges; thus wide variations in nutrients tend to be eliminated.

Second, because it is frozen, Minute Maid loses none of its ascorbic acid content before reaching the consumer.[3] Whole fruit, however, is subjected to variations in temperature, and care in handling cannot be maintained from tree to table. Laboratory tests have shown an average ascorbic acid loss of 10.7% in whole oranges after 11 days under simulated storage and shipping conditions.

Peel oil, cause of allergic response and poor tolerance, especially in infants,[4] is held to an arbitrary minimum in Minute Maid. Samples of home-squeezed juice expressed by typical housewives showed peel oil contents up to 700% higher.

Bacterial counts were found to be as high as 350,000 per ml. in home-squeezed samples—but were uniformly low in Minute Maid. Technicians ascribe this to the combination of rigid sanitary controls in the Minute Maid process and the low pH and low temperatures at which the juice is kept. High bacterial counts in home-squeezed juice are doubtless due to contamination from the exterior peel which is unknowingly added to the juice during preparation.

In view of the above findings, more and more physicians now specify Minute Maid Fresh-Frozen Orange Juice in lieu of home-squeezed orange juice.

REFERENCES

(1) *Rakieten, M. L.,* et al., *Journal of the American Dietetic Association, October, 1951.*

(2) *U. S. Department of Agriculture Technical Bulletin No. 753, December, 1940.*

(3) *Roy, W. R., and Russell, H. E., Food Industries, Vol. 20, pp. 1764-1765 (1948).*

(4) *Joslin, C. L., and Bradley, J. E., Journal of Pediatrics, Vol. 39, No. 3, pp. 325-329 (1951).*

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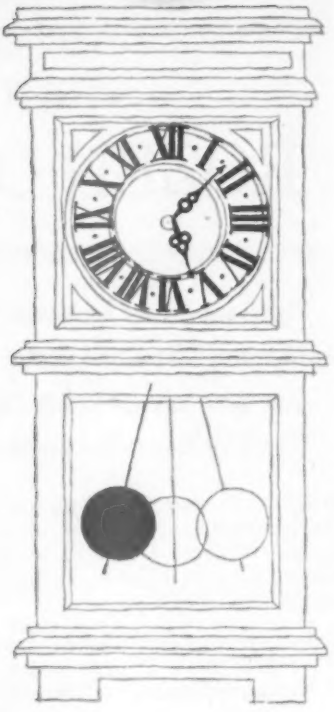

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Bactine gives prolonged protection. It kills bacteria on contact and then continues its antibacterial action for hours.

3 minutes, washing with *Bactine,* as shown by hand disinfectant tests, leaves hands surgically clean—with a greater reduction in removable organisms than the eight minutes with the conventional soap and alcohol surgical scrub.

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4 hours later hands still show antibacterial action of *Bactine.*

Use Bactine for hands • skin prep • first aid • work surfaces • instruments

Bactine: At all pharmacies in 1 gallon, 1 pint, 6 ounce and 1¾ ounce bottles.

MILES LABORATORIES, ELKHART, INDIANA

through the years has obtained a first-hand knowledge of bookkeeping. A supervisory committee of three members examines Credit Union accounts at least four times a year and sees that the agency operates according to state laws and the by-laws of the association. This committee also OK's loans and is generally responsible for the financial condition of the Union. Needless to say, any information on loans is held in the strictest confidence by committee members.

That the financial condition of the Nurses Credit Union is currently sound is shown by the following statistics. After 13 years of operation, savings rose to an all-time high of $15,635 on November 30, 1951. Much of this increase—about $12,000 in 1950-51—can be attributed to publicity in the official publication of the Minnesota State Nurses Association in 1950, and to talks before various nurse groups. One hospital has already adopted the Credit Union savings plan for payroll deductions.

One of the latest proposals to come from the Nurses Credits Union is that of establishing an agency for paying MSNA dues through fractional payment methods. Under a plan for non-Credit Union members, yearly dues would be divided into monthly or quarterly payments to the Credit Union. For example, if dues were $26.50, the nurse would pay $6.65 quarterly or $2.20 monthly. On December 31, of each year, the treasurer of the Credit Union would send a check for $26.50 to the district for the following year's dues.

There is still another plan limited to nurses of the Twin Cities which enables them to pay their dues for this coming year. A nurse who chooses this method may apply to the Credit Union for a loan of $25 in January for payment of dues. As a regular Credit Union member, she will start paying this back in February at the rate of $5 a month for five months plus interest totaling 84c. She can continue to save $5 a month for the next five months and if she wishes to withdraw on the first of January will receive her savings plus 4 per cent accrued interest. However, if she keeps her savings in the Credit Union she can reborrow $25 for her 1953 dues. Credit Union officers are enthusiastic about these

methods of payment, which have received MSNA support, for they realize —more than most—the large number of nurses who cannot stretch their budgets to cover professional dues. They know, too, that something has to be done about their state nurses association's drop in membership.

It should be emphasized that the Credit Union is not competing with banks, for these institutions prefer to handle large amounts of money; rather, it is geared to the small investor. Perhaps the most outstanding feature of the Twin Cities Nurses Credit Union which differentiates it from other savings and loan institutions is its belief in, and understanding of, nurses. It is this quality which enables it to carry a loan for several months without payment if the borrower is overcome by a series of financial disasters. As one officer of the Credit Union says: "We can afford to be patient with members when they have unexpected difficulties because we are more interested in service than in profit."

The credit union idea, which has achieved such success in Minnesota, is also making headway in Colorado under the auspices of the Denver Chapter, Archdiocesan Council of Catholic Nurses. The Denver credit union, organized in the fall of 1946 by Mrs. Dorothy Hoell, a graduate of the Mounds Midway School of Nursing, St. Paul, Minn., provides the same savings and loan features of other credit unions. Membership is open to ACCN members, their immediate families and student nurses.

[*Continued from page* 54]

active Committee on Federal Legislation continued its legislative work in behalf of H.R. 910 (the Bolton bill) and its companion S. 2301 (Ives bill) at the January session of Congress . . . Nineteen states passed new laws or amendments to nursing practice acts. Bills did not pass in six states. The training and licensure of practical nurses or others with equivalent preparation is now provided for by law in 36 states and two territories . . . The Communist World Federation of Democratic Women is sponsoring the International Conference in Defense of Children to be held in Vienna, February 1952, according to information given to the ANA by the National Health Council. Noted individuals have been solicited to act as sponsors of this Conference but its background has not been revealed to them . . . Organized Private Duty Sections now number 48—this includes the District of Columbia—and there are now 38 General Duty Nurses' Sections.

▶ FOREIGN NURSES desiring O.B. experience may enroll in the postgraduate course in obstetric nursing offered by the Margaret Hague Maternity Hospital in Jersey City, N.J. This course was designated as an Exchange-Visitor Program for qualified students by the State Department in Washington under a provision of the U.S. Information and Educational Exchange Act of 1948.

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1. Light up either one. Take a puff — don't inhale — and s-l-o-w-l-y let the smoke come through your nose.

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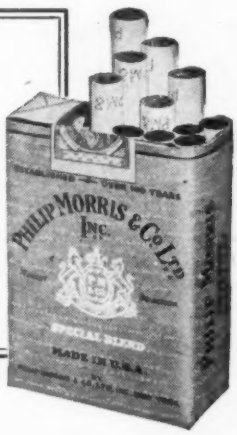

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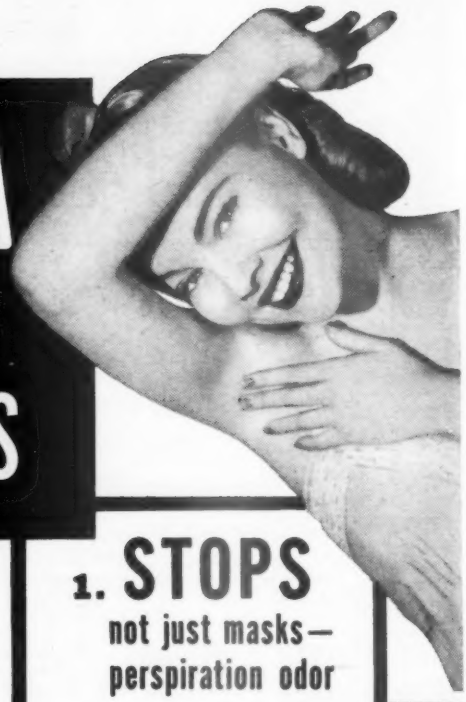

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ADMINISTRATORS-NURSES: (a) 30 bed general hospital and clinic, excellent California location. Salary to $5000. (b) 50 bed Texas hospital, modern and well staffed. (c) 20 bed general hospital soon to be expanded, prosperous community southeastern Nebraska. $4200. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

ANESTHETISTS: (a) Two; hosp. affil. 26 man group; coll. town, NW. $4000, mtce. (b) To adm. anes. for group of Amer. Board men; univ. town, So; $6000. (c) Two; large gen'l. hosp; interesting city outside U.S.; tropical but mild climate. (d) Anes-supt; 75 bed hosp; Pac. NW. (e) New hosp. 300 beds; Med. anes. in charge; attrac. location; E. RN2-2 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

ANESTHETISTS: (a) Small, modern hospital, attractive Pacific Coast location. $6000 yearly. (b) 80 bed Georgia hospital, Atlantic resort city 10,0000. $4800 maintenance. (c) Large New York hospital, excellent Long Island Sound location. $4200 maintenance. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

ASST. DIRECTOR OF NURSING: For 390 bed tuberculosis hospital with modern 265 bed addition near completion, affiliated with Western Reserve University. 40 hour, 5 day week, holidays, vacation, sick leave and retirement plan. Maintenance optional at minimum rate. Salary open. Apply to: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

ASS'T LABORATORY TECHNICIAN: Young lady with some experience. Salary $150 month with full maintenance. Apply Medical Director, Florida State Hospital #2, Arcadia, Fla.

ASST. SURGERY SUPERVISOR: Also, Operating Room Staff Nurses needed immediately. 5 day, 40 hour week. Salary open. Inquire Director of Nurses, Palo Alto Hospital, Palo Alto, Calif.

CLINICAL INSTRUCTOR AND ASST. SUPERVISOR IN OPERATING ROOM: Extensive clinical facilities provide good teaching opportunities. Write Director of Nursing for outline of duties and conditions of employment. Salary open. Miami Valley Hospital School of Nursing, Dayton, Ohio.

DIRECTORS OF NURSES: (a) Gen'l. hosp., 400 beds; collegiate school; univ. town, So. (b) Gen'l. 225 bed hosp; affil. med school; oppor. continuing studies; MW. (c) Teaching hosp; excel. school; E. (d) Gen'l. 200 bed hosp., affil. univ; SW. RN2-3 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

DIRECTORS OF NURSING: (a) 80 bed general hospital and clinic. City 10,000 vicinity California state capital. Minimum $4200. (b) Large midwest psychiatric hospital. $5400. (c) Pediatric teaching unit, eastern college of nursing. $6000, maintenance. (d) Assistant. Large eastern tuberculosis hospital. $5000. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

DIRECTORS OF NURSING SERVICE: (a) New hosp. fairly large; Calif. (b) New hosp; small size; resid. town; near NYC. (c) Gen'l. hosp., 100 beds; Pac. NW. (d) Gen'l hosp. oper. under Amer. auspices in So. Amer; knowledge of Spanish req. RN2-4 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

FACULTY APPOINTMENTS: (a) Educational Director. Highly rated 125 bed midwest hospital, Master's Degree desired. $4800. (b) Clinical Instructor. Medical-surgical students, college of nursing midwest state capital. $5000. (c) Pediatric Nursing Instructor. Southern college of nursing. To $5000. (d) Nursing Arts Instructor. Southeastern university hospital. $4000 up. (e) Science Instructor. Small approved teaching hospital, eastern educational center. $4800. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

FACULTY POSTS: (a) Educ. dir; collegiate prog; univ. center; $5000. (b) Med-surg. clinical instruc; univ. prog; $5000, MW. (c) Educ. dir. & nursing arts instruc; 300 bed hosp; coastal city, E; $4000 & $3600 respectively, mtce incl. (d) Educ. dir. and nursing arts instruc; small hosp; college town near Chgo; $6000, $4800, respectively, mtce. (e) Instructor; school for Turkish, Greek, Armenian nurses; students have equiv. high school ed., understand English; school conducted under Amer. auspices; Near East. RN2-5 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

GENERAL DUTY NURSES: For Medical, Surgical Floors and Operating Room. Starting salary $10 per day, 40 hr. week, bonus for P.M. and night duty. Alternating shifts when necessary. Perm. P.M. & night duty $10.74 per day. Living quarters $18 month. Excellent transportation to all areas. Write Director of Nurses, Doctors Hospital, 12345 Cedar Rd., Cleveland Hts. 6, Ohio.

GENERAL DUTY NURSES: On all services including Operating Room. General Hospital. Fully approved, 44 hour week day duty, 40 hr. week 3-11; 11-7 shifts with differential of $10

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a month. Starting salary $200 per month. 7 holidays, vacation, sick time allowance. Apply Director of Nurses, Franklin Square Hospital, Baltimore 23, Md.

GENERAL DUTY R.N.'s: Top salary. All benefits. Small general hospital, few miles from Los Angeles. Write Director of Nurses, Bixby Knolls Hospital, Long Beach, Calif.

GENERAL DUTY REGISTERED NURSES: Wanted in Molokai Hawaii. Small community hospital. Starting salary $260, Social Security, complete maintenance and car available, annual vacation and sick leave. Write Laura G. Van De Mark, Administrator, Molokai Community Hospital, Hoolehua, Molokai, Hawaii.

GENERAL STAFF DUTY NURSES: All areas. Apply to Director of Nursing, George F. Geisinger Memorial Hospital, Danville, Pa.

GENERAL STAFF NURSES: 165 bed general hospital in residential suburb of Chicago. Medical, surgical, pediatric, obstetrical and operating room divisions. 44 hour week, 2 weeks vacation, 6 holidays, sick leave policy. Salary $190 days, $200 evenings, night duty $205, plus complete maintenance in new nurses' residence opened June 1, 1951. Salary increase $10 per month after 60 days. Scrub nurses remuneration for call. Leave of absence for post graduate experience with part salary. Apply to Director of Nursing, MacNeal Memorial Hospital, Berwyn, Ill.

GENERAL STAFF NURSES: 200-300 bed hospital (100 beds open March 1952). Liberal personnel policies including a 40 hour week. Write: Director of Nursing, Holston Valley Community Hospital, Kingsport, Tenn.

GENERAL STAFF NURSES: 250 bed general hospital and 72 bed maternity hospital. Starting salary $225, $5 per month tenure increase for each 6 months of service to a maximum of $255. Two meals daily, Social Security, sick leave prepaid, medical and hospital care, $10 additional for afternoon and night duty, $15 additional for delivery room, $20 additional for surgery, up to 3 weeks vacation at end of 5 years, 6 paid holidays, 8 hour day, 40 hour week. Apply to Director of Nurses, Sutter Hospital, Sacramento, Calif.

GENERAL STAFF NURSES: 144 bed hospital located in Southern Colorado near mountain resorts. 44 hour duty, liberal personnel policies including Social Security. For information write Director of Nurses, Parkview Episcopal Hospital, Pueblo, Calif.

GRADUATE STAFF NURSES: For medical, surgical and obstetrical services. Also vacancies on operating room staff. Salary $230 per month for 8 hour day, 40 hour week. Annual vacation and sick leave. Retirement benefits if desired. Apply Superintendent, Robinson Memorial Hospital, Ravenna, Ohio.

INDUSTRIAL AND OFFICE: (a) Industrial. Duties include screening personnel; lge. co.; Chicago. (b) Office Nurse by Board specialist; Florida. (c) Industrial; new plant; univ. town. So. (d) Office Nurse by surgeon. FACS; town 50,000, West. RN2-6 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

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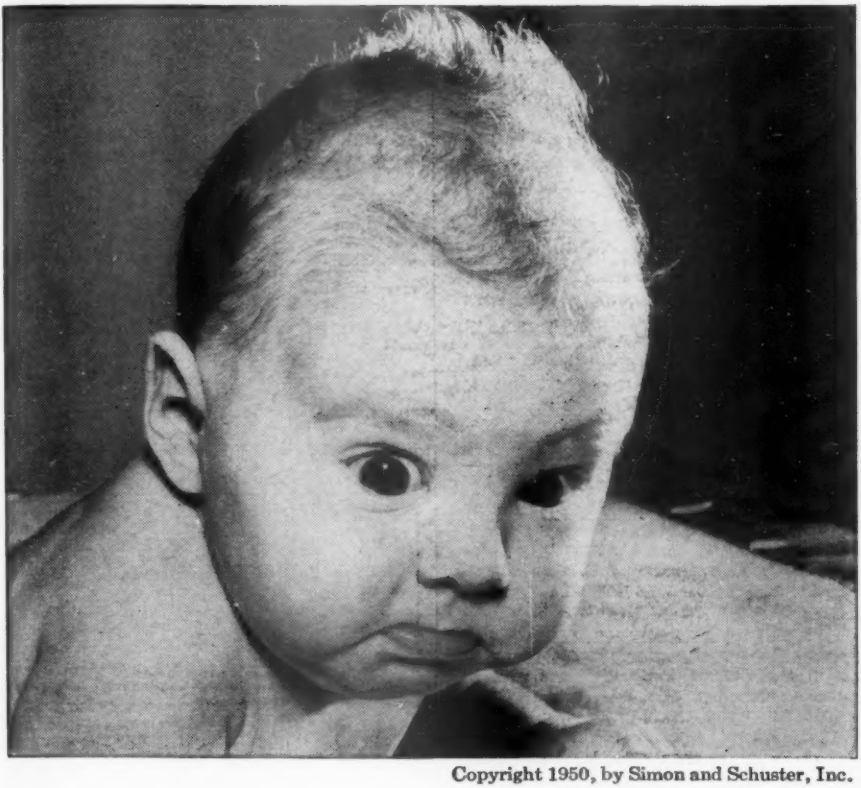

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MALE NURSES: (a) O.R. Supervisor; 175 bed hosp. So; (b) Anes; new 300 bed hosp; Chicago area; (c) Industrial. Alaska. (d) Hosp. and clinic, Amer. company; Asia. (e) Industrial; large plant; Chicago. RN2-7 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

NURSE: Who would like to swap her experience for board and tent in a Girl Scout Camp in the Colorado mountains this summer. A little money thrown in on the side. For further particulars write Miss Shirley McVoy, Director of Lazy Acres, 322 W. 5th St., Pueblo, Colo.

NURSE ANESTHETIST: New York Suburb. Approved 200 bed hospital, complete maintenance. Salary $350, one month vacation. Apply United Hospital, Port Chester, N.Y.

NURSE ANESTHETISTS: Two vacancies. A.A.N.A. Member. 626 bed general hospital, 10 Nurse Anesthetists on staff. Good salary and hours. Liberal personnel policy. Apply Chief Anesthetist, Good Samaritan Hospital, Cincinnati 20, Ohio.

NURSES: Operating Room and General Duty. 150 bed hospital. Liberal personnel policies. Apply Director of Nursing, East Orange General Hospital, East Orange, N.J.

NURSES: Operating Room and General Duty R.N.'s. 40 hour week, 8 hour duty, 300 bed Tuberculosis Hospital, 25 miles from New York City. Salary $200 per month and maintenance with bonus of $20 per month after 3

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effects 95% reduction in skin bacteria

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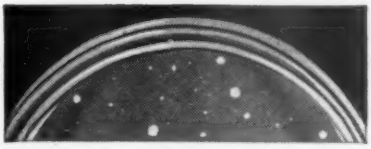

With ordinary soap. Even after thorough washing, thousands of active bacteria remain on the skin.

With Dial soap. Daily use of Dial with Hexachlorophene eliminates up to 95% of resident skin bacteria.

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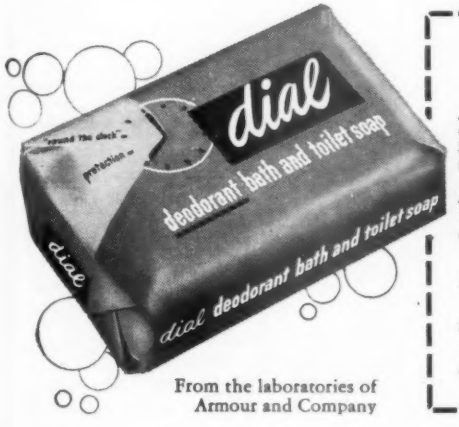

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month's service. Apply Superintendent of Nurses, Bonnie Burn Sanatorium, Scotch Plains, N.J.

NURSES: Moving to new hospital and new apartment-style nurses' residence April 1, 1952. 236 bed general hospital 30 miles from New York City. Wanted immediately: Supervisors, Head Nurses, Assistant Head Nurses, General Duty Nurses. Liberal personnel policies. Write Director of Nursing, Morristown Memorial Hospital, Morristown, N.J.

NURSES: General duty, head and supervisory nurses in acute communicable, TB or general emergency nursing; public health nurses and public health nurses in training. Salaries from $3268 to $5008 per yr., annual increases, 40-hr. week, no split shift, paid vacations, sick leave, duty disability allowances, death and sickness benefits, pensions, maternity leaves, educational leaves, in-service training, opportunities for further schooling. Apply: Detroit Civil Service Commission, 735 Randolph Street, Detroit 26, Mich.

NURSES: General Duty, for 30 bed hospital. 35 miles from New York. Excellent salary. Apply Administrator, Tuxedo Memorial Hospital, Tuxedo Park, N.Y.

NURSES: Choice of duty in three modern hospitals. General duty, $230 month to start; surgical, $236 month to start; relief shift, $10 extra. Two weeks paid vacation; six paid holidays; medical and hospital benefit plan. Contact Roy Watson, Jr., Kahler Hospitals, Rochester, Minn.

NURSES: Operating room and general duty. 42 bed new well-equipped hospital. 40 hr. week, top salary. Apply Administrator, Tracy Hospital, Tracy, Calif.

NURSES: For 90 bed hospital, 40 hour week, sick leave and vacation with pay and other benefits of State Merit System. Salaries: Charge Nurse, $260, (2 years of hospital nursing required), Nurse, $220. Apply Superintendent of Nurses, State Tuberculosis Hospital, Gooding, Ohio.

NURSES: Wanted immediately. Nursing Arts Instructor, Obstetrical Teaching Supervisor, O.R. Nurses, General Duty Nurses. Liberal personnel policies. Write Director Nurses, Lutheran Hospital (Memorial) Newark, N.J.

NURSES: Surgical and Operating Room Nurses. Post-graduate course and experience in surgical nursing and operating room technique. Salary: Head Nurse, $2760.00 to $4320.00. Supervising Nurse, $3024.00 to $4800.00. Write Supervisor, Personnel Service, Department of Public Welfare, State Armory, Springfield, Ill.

NURSING ARTS INSTRUCTOR: Immediate opening in 100 bed General Hospital with 50 students. Hospital located about 40 miles from Boston. Salary open. Contact Director, School of Nursing, Nashua Memorial Hospital, Nashua, N.H.

OBSTETRICAL NURSE: With advanced preparation and experience, also general duty nurses. Apply Director Nursing Service, St. Joseph's Riverside Hospital, 1400 Tod, N.W., Warren, Ohio.

OPERATING ROOM SCRUB NURSE: Experienced. 60 bed non-profit hospital at Carmel-by-the-Sea. Salary $260 to start. 5 day week, pleasant living quarters. Write Peninsula Community Hospital, Box H-Hy Carmel, Calif.

PUBLIC HEALTH NURSES: Needed for generalized service in local health departments in Georgia. Entrance salary $2760 with advancements to $3480. Travel allowance for use of personal car. Liberal retirement benefits. Opportunities for further training. Write Personnel Administrator, State Health Department, State Office Building, Atlanta, Ga.

PUBLIC HEALTH AND SCHOOL: (a) Industrial nursing consultant; state health dept.; (b) School nurse; public schools; So. Calif; (c) College nurse; small college; Pac. N.W.; RN2-8 Burneice Larson, Medical Bureau, Palmolive Building, Chicago.

PUBLIC HEALTH NURSES: New York City Department of Health. Immediate appointment on provisional basis. Generalized service includes maternal and child care, school health and communicable disease control. Starting salary $2650, 37 hour week, liberal vacation and sick time allowance, pension rights, in-service training. Applicants (ex-

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All day long you have your hands in and out of water. This is hard on your skin, makes the protective action of TRUSHAY doubly important.

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You want your hands to be soft and smooth, without signs of constant washings. TRUSHAY—the "beforehand" lotion will keep them lovely.

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When patients and friends wonder how you can keep your hands so soft and smooth and free from redness in spite of frequent soap-and-water scrubbings, tell them about TRUSHAY, the lotion with the "beforehand" extra.

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cept New York State Veterans) must not have reached 36th birthday. Write to Bureau of Public Health Nursing, City Health Department, 125 Worth St., New York 13, N.Y.

REGISTERED NURSE: For general duty, salary $200 month with full maintenance. Apply Medical Director, Florida State Hospital #2, Arcadia, Fla.

REGISTERED NURSES: For all services. 120 bed general hospital, 40 hour week, beginning salary $215 a month. Regular salary increases, 2 weeks vacation annually, sick leaves, holidays, full maintenance available at reasonable rate. Apply Director of Nurses, Saint Mary Hospital, Pueblo, Colo.

REGISTERED NURSES: The City Beautiful welcomes qualified registered nurses. Dayton is an industrial city with many attractive features including good bus service directly to the hospital and opportunity to continue study toward a degree. Staff nurses are offered an option of a 40, 44 or 48 hour week. Salaries range from $217.50 to $295.50. Drop a post card to Director of Nursing, stating preference for assignment. Full information will be sent. Miami Valley Hospital, Dayton, Ohio.

REGISTERED NURSES: Hermann Hospital in the Texas Medical Center offers you unlimited opportunities. Positions with pleasant working conditions are available now. Write Director of Nurses, Hermann Hospital, Houston, Tex.

REGISTERED PROFESSIONAL NURSES: Obstetrics, operating room, medical-surgical services. 40 hour week. $9.70 per day, $10.35 per evening or night. Three month and annual increases. Free laundry uniforms. Progressive vacation, liberal sick leave. Reasonably priced living quarters in hospital vicinity. Write Director of Nurses, Glenville Hospital, Cleveland 8, Ohio.

STAFF NURSES: (a) Several; new hosp. gen'l, 350 beds, affil. univ. med. school; staff of 60 Board specialists; more than 100 residents in various specialties; (b) Two; small hosp; Alaska. (c) Several; gen'l hosp; Pacific Islands; $3900; mtce. RN2-9 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

STAFF NURSES: In hospital for children with rheumatic fever. Excellent salary, good working conditions, maintenance, vacation. Near New York City. Apply Medical Director, Irvington House, Irvington, N.Y.

STAFF NURSES: City of 46,000 with unusual cultural and educational opportunities. Wide choice of working experience in 1100 bed hospital. 40 hour, 5 day week, 6 holidays and 2 weeks vacation with pay. Salary $257.50 for rotating time schedule. Scheduled salary increases based on merit. Generous illness allowance and medical benefits. Room in graduate nurse housing for $2 or $30 if desired. For further details please write Director of Nursing, University Hospital, Ann Arbor, Mich.

SUPERVISORS: (a) Two. O.B. and night; new hosp, small size; fashionable college town, near Chicago; oppor, continuing studies. (b) Clinic superv; 15 man group; NW; $4800. (c) O.R.; large techg. hosp; staff, 16 nurses, 8 aides; $5000. (d) Pediatric. 40 bed unit; univ. hosp; medical center; E. (e) O.B.; new hosp, unit univ. group; SW. (f) Ortho; new

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He lunches hurriedly at 3 a.m.—goes to bed when most folks' alarm clocks start ringing. All too often, upside-down eating can lead to a subclinical vitamin deficiency. For Roger and other dietary digressors, many physicians offset poor vitamin intake by prescribing one or two Dayalets a day. Dayalets are fishless, burpless tablets containing nine important vitamins—including B_{12}. Dayalets contain synthetic vitamin A—no fish-oil taste or burp, no allergies due to fish oils. They're better tolerated by patients than soft, gelatin capsules. Supplied in bottles of 50, 100 and 250. Abbott

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dept. 300 bed hosp; college town. MW. (g) Two. Psy. & Ped; long estab. hosp. affiliated univ; charming town, deep So. (m) Surg; new hosp, one of Alaska's most attrac. towns. RN2-10 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

SUPERVISORS: (a) Clinical. Large, approved teaching hospital, middle east educational center $3600. (b) Medical Floor. 200 bed Pennsylvania hospital. $3600 minimum. (c) Obstetrical. 50 bed unit, large Arizona teaching hospital. Open. (d) Operating Room. Large teaching hospital, southern Atlantic Coast location. $3600 maintenance. Woodward Medical Bureau, 185 N. Wabash, Chicago, Ill.

SURGICAL NURSE: Experienced, for 33 bed general hospital, salary $240 per month, 4 weeks paid vacation, sick leave. Apply: Superintendent, Nantucket Cottage Hospital, Nantucket, Mass.

SURGICAL NURSES: (a) Small hosp; resort town, No.; $300, mtce; (b) Three; gen'l hospitals under Amer. auspices; South America. (c) Private practice group; 20 Amer. Board Men; college town; MW. RN2-11 Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

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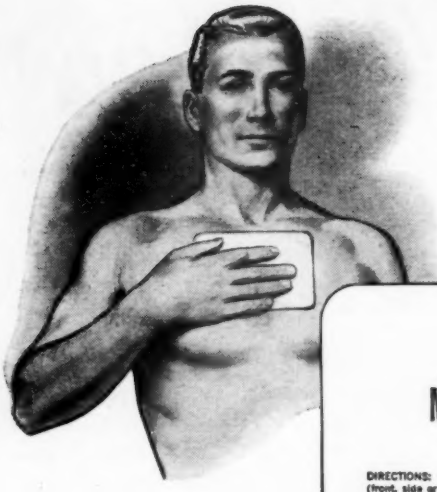

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MUSTARD PLASTER

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EXTRA-LARGE SIZE

DIRECTIONS: Soak the plaster in lukewarm water (1 to 2 minutes) and apply to chest (front, side or back). Remove plaster when skin is thoroughly reddened, usually within 5 to 10 minutes.

CAUTION: Do not keep plaster on long enough to blister the skin—never over 15 minutes. If blistering occurs because plaster is left on longer than 15 minutes, apply Johnson's Baby Cream or Petroleum Jelly to soothe the irritated area. When used on children or adults with sensitive skin, place a layer of wet gauze or cloth between plaster and skin.

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For chest colds

The time-proved mustard poultice in modern, ready-to-use form

The old-fashioned mustard poultice has long been recognized as sound therapy. For example, Blumgarten's "Textbook of Materia Medica, Pharmacology and Therapeutics," 1937, notes that rubefacients or counter-irritants are useful "to relieve pain and tightness in the chest and congestion and inflammation in the lungs."

Whenever this type of treatment is indicated, you will find that Johnson's MUSTARD PLASTERS offer many advantages to your patients. Each plaster comes ready to use. Nothing to prepare. No mess. No fuss. On and off in a few minutes. Heats the spot, stimulates circulation, helps relieve chest colds, bronchitis, sore throat.

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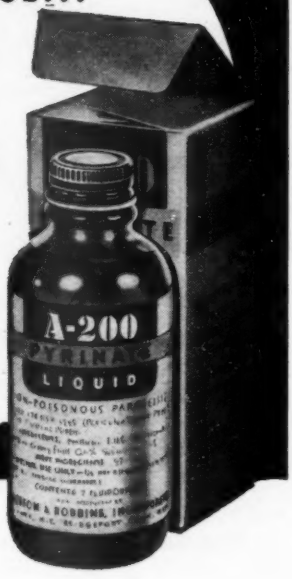
Kills head, crab, body lice and their eggs... on CONTACT!



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DOUBLE-RICH in the food values of whole milk.

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Dosage: One to three capsules daily or as directed by the physician.

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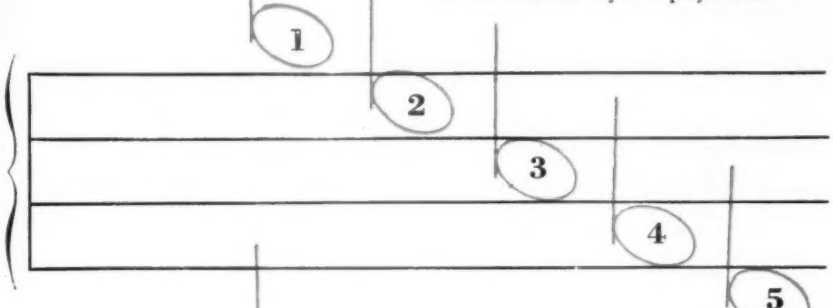

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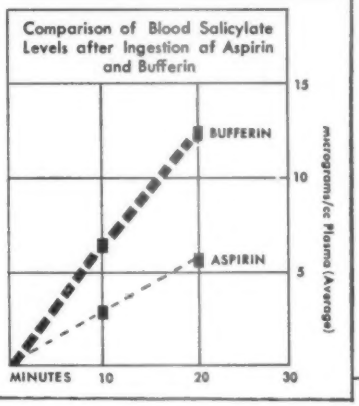

2 DOES NOT UPSET THE STOMACH

Bufferin's antacid ingredients protect the stomach against aspirin irritation. This has been clinically demonstrated on hundreds of patients.

In usual doses

In a series of 238 cases, 22 had a history of gastric distress due to aspirin but only one reported any distress after taking 2 Bufferin tablets (equivalent to 10 grains of aspirin).[1]

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In a recent study group, 1006 patients received, over a 24 hour period, 12 Bufferin tablets (equivalent to 60 grains of aspirin). Although 72 had a history of being sensitive to aspirin, only 18 reported any gastric side-effect with Bufferin.[2]

1. Effect of Buffering Agents on Absorption of Acetylsalicylic Acid. J. Am. Pharm. Assoc., Sc. Ed. 39:21, Jan. 1950

2. Gastric Tolerance for Aspirin and Buffered Aspirin. Ind. Med. 20:480, Oct. 1951

AVAILABLE in vials of 12 and 36 tablets and in bottles of 100. Tablets scored for divided dosages.

INDICATIONS: Simple headaches, neuralgias, dysmenorrhea, muscular aches and pains, discomfort of colds and minor injuries. Particularly useful when gastric hyperacidity is a complication. Useful for relieving pain in the treatment of arthritis. Helpful for toothaches and pain following tooth extraction.

EACH BUFFERIN TABLET contains 5 grains of acetylsalicylic acid, together with optimum amounts of the antacids aluminum glycinate and magnesium carbonate.

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